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Abortion Services In the United States, Each State & Metropolitan Area, 1984–1985

Edited by Stanley K. Henshaw and Jennifer Van Vort

The Alan Guttmacher Institute
An Independent, Non-Profit
Corporation for
Research, Policy Analysis
and Public Education

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INTRODUCTION

This volume makes available in one source the results of the abortion research program of The Alan Guttmacher Institute (AGI) from 1985-1987. This is the seventh such volume, the first of which was published in 1975. It contains three research articles based on the AGI Abortion Provider Survey, nine other pieces relating to abortion published by the AGI, a description of the methodology used in the fielding and analysis of the Abortion Provider Survey, and detailed tables of statistics on abortion utilization, abortion services, and teenage pregnancy.

The Abortion Provider Survey, which is the basis of much of the AGI's abortion research, was conducted each year from 1974 through 1979, 1981, 1983, and 1986. The data collected cover the years 1973-1985 with the exception of 1983. The next survey is tentatively planned for 1989 to cover the years 1987 and 1988.

The purposes of the surveys are, first, to monitor the availability of abortion services in all geographic areas of the country, and second, to collect information, varying from year to year, about abortion providers and the services they offer. For each survey, a questionnaire is sent to all facilities in the United States where abortions are believed to take place, including public and private hospitals, nonhospital clinics and private physicians' offices. As a result of intensive follow-up procedures, the survey produces the most complete available count of the number of abortions performed in the United States and in each state, metropolitan area and county. The results are summarized by the U.S. Department of Commerce in the Statistical Abstract of the United States.

The only other major source of national data on abortion services is the DHHS's Centers for Disease Control (CDC), Division of Reproductive Health. Each year the CDC compiles data from the central health agencies of the states which collect such data - 44 plus the District of Columbia in 1983 - and from hospitals and other facilities in the remaining states. Data are assembled on the number of abortions, the characteristics of women obtaining abortions, and medical aspects of the procedures. The safety of abortion is one of the CDC's chief concerns. Its abortion surveillance effort and Joint Program for the Study of Abortion/CDC provide information on abortion morbidity and mortality as well as on methods of abortion and period of gestation at which abortions are obtained, both of which affect the risk of complications. Since a number of states do not require reporting and others do not have complete reporting, the CDC reports identify fewer abortions than do the AGI surveys. The CDC figures were 84 percent of AGI levels in 1979 and 1980, 82 percent in 1981 and 83 percent in 1982. In AGI reports, AGI counts of abortions and CDC information about the characteristics of the women obtaining abortions are used. A detailed description of the AGI Abortion Provider Survey methodology and the incorporation of the CDC data may be found in the section of this volume entitled "Survey Methodology."

The first three articles reproduced in this volume are based on the Abortion Provider Survey. The first summarizes abortion data for 1984 and 1985: trends in the number and rate of abortions in the United States, the geographic availability of abortion services, and the types of facilities in which abortions take place. Data are presented on the fees charged, the acceptance of Medicaid payment for abortions, the provision of services at reduced fees for poor patients, and the availability of second-trimester services.

The second article describes the characteristics of women obtaining abortions in 1983: age, race, marital status, number of live births, prior induced abortions, gestational age, and abortion procedure used. Pregnancy rates of white and nonwhite teenagers from 1977 to 1983 are shown. The third article describes the degree and type of anti-abortion harassment experienced by abortion providers.

Following these are some but not all of the other work relating to abortion published by The Alan Guttmacher Institute. Included are two pieces relating to Medicaid coverage of abortion, three concerned with attitudes of the public and of physicians, two about the training of abortion service providers, one analyzing the effect of abortion on birth rates, and one describing the extent of unintended pregnancy in the United States.

The "Detailed Tables" section is a compilation of abortion statistics not available in any other single source. Tables 1-4 contain data for each year from 1973 through 1983 on the abortion procedure and the following characteristics of women having abortions: age, race, marital status, number of live births, number of prior induced abortions, and weeks of gestation. Tables 5-7 give the number of abortions and providers for states and standard metropolitan statistical areas. Tables 8-11 present state abortion numbers and rates for all the years for which these data are available. Teenage pregnancy rates by state are shown in Tables 12-15. The pregnancy rates require abortion data for calculation and are not generally available elsewhere.

ARTICLES

Abortion Services in the United States, 1984 and 1985

By Stanley K. Henshaw, Jacqueline Darroch Forrest and Jennifer Van Vort

Summary

In 1984 and 1985, the number of abortions, the abortion rate and the abortion ratio stayed at approximately the same levels as in the previous three years. Just under 1.6 million abortions were performed, about three percent of women of reproductive age obtained an abortion, and about 30 percent of pregnancies (excluding those ending in stillbirths and miscarriages) were terminated by abortion.

However, the number of abortion providers declined by five percent between 1982 and 1985, and the geographic distribution of abortion services continued to be markedly uneven. Eighty-two percent of all U.S. counties—50 percent of those classified as metropolitan and 91 percent of those classified as nonmetropolitan—lacked an abortion provider in 1985.

The long-term trend away from hospital abortions persisted during the period: Eighty-seven percent of the abortions performed in 1985 were done in nonhospital facilities, an increase of five percentage points over the 1982 level. Although abortion clinics constituted only 15 percent of all providers, they were responsible for 60 percent of the procedures performed in 1985.

Among all abortion facilities, only 43 percent provided services to women after the 12th week of pregnancy. Abortion clinics were far more likely to offer second-trimester procedures than were other types of abortion providers (75 percent, compared with 13–50 percent).

As of mid-1985, charges for a first-trimester nonhospital abortion ranged from $75 to nearly $900. The average amount paid was $213. In 1985, only 39 percent of nonhospital abortion facilities accepted state reimbursement for abortions provided to low-income women, and only 55 percent of facilities offered some reduction in charges to such women.

Methodology

To monitor the availability and utilization of abortion services in the United States, The Alan Guttmacher Institute (AGI) has conducted periodic national surveys of all known abortion providers. The ninth such survey, covering the years 1984–1985, was fielded in 1986. (The previous survey, for the years 1981–1982, was conducted in 1983.) Questionnaires were sent to all hospitals, clinics and doctors' offices known to have provided abortions in 1981 or 1982 or thought to have provided them more recently. Possible new providers were identified through queries to the executive directors of all Planned Parenthood affiliates and the state coordinators of the National Abortion Rights Action League; from lists provided by some state health departments; through newspaper articles from a national clipping service; and by checks of the telephone yellow pages of all U.S. cities. We believe that these sources furnished the names of virtually all facilities that advertise their services or that receive significant numbers of patients through referrals.

The information solicited in the questionnaire included the numbers of abortions provided in 1984 and 1985, the numbers of second-trimester procedures, gestational limits for the performance of abortion and experience with antiabortion harassment.* In addition, nonhospital facilities were asked about the proportion of services related to abortion, usual charges, special provisions for low-income patients, use of anesthesia, and security, insurance and other service problems possibly linked to the provision of abortion.

Two or three follow-up letters were sent to facilities that did not respond to the questionnaire. If there was still no response, we used state health department data for individual facilities, if available. Otherwise, we attempted to elicit the information by telephone. Unless a provider flatly refused to participate, a minimum of three calls were made to almost all of the facilities that did not respond, and at least six calls (and sometimes twice that many) were made to facilities thought to have provided 400 or more abortions. In most of the few instances in which these efforts were unsuccessful, we obtained estimates from knowledgeable persons in the community. Information obtained by telephone or from sources other than the completed questionnaire consisted of the number of abortions provided in 1984 and 1985 and, in some cases, the maximum gestation at which abortions were performed.†

These efforts enabled us to obtain information for 94 percent of the known or anticipated abortion providers—a proportion somewhat lower than the 96 percent attained in the previous survey. In 1986, many hospitals and nonhospital facilities were reluctant to provide any information about abortion because of fear of antiabortion harassment; many had already been the targets of protesters. Year-to-year comparisons of the number of providers need to take into account the increased rate of nonresponse. If all the nonrespondents in the most recent survey are assumed to have performed abortions in 1985, then the total number of providers has been undercounted by 87 facilities (three percentage points) more than it was in the prior survey.

Because the most intensive follow-up efforts were concentrated on the larger provid-

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*For a detailed analysis of the data on harassment, see J. D. Forrest and S. K. Henshaw, "The Harassment of U.S. Abortion Providers," *Family Planning Perspectives*, 19:9, 1987.

†For a more detailed explanation of the survey methodology, which was essentially the same as that used in 1983, see S. K. Henshaw and E. Blaine, eds., *Abortion Services in the United States, Each State and Metropolitan Area, 1981–1982*, The Alan Guttmacher Institute, New York, 1985, pp. 51–60.

Table 1. Number of reported abortions and number of providers, by metropolitan status;* rate of abortions per 1,000 women aged 15–44; and ratio of abortions per 1,000 abortions plus live births; United States, 1973–1985

Measure and metropolitan status	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
No. of abortions (in 000s)	**744.6**	**898.6**	**1,034.2**	**1,179.3**	**1,316.7**	**1,409.6**	**1,497.7**	**1,553.9**	**1,577.3**	**1,573.9**	**1,575.0**	**1,577.2**	**1,588.6**
Metro	720.2	860.7	985.7	1,123.3	1,258.0	1,345.2	1,430.9	1,507.7	1,538.3	1,537.3	u	1,543.9	1,556.4
Nonmetro	24.4	37.9	48.5	56.0	58.7	64.4	66.8	46.2	39.0	36.6	u	33.3	32.2
No. of providers	**1,627**	**2,026**	**2,396**	**2,567**	**2,688**	**2,753**	**2,734**	**2,758**	**2,896**	**2,908**	**u**	**2,710**	**2,680**
Metro	1,302	1,615	1,903	2,036	2,139	2,198	2,213	2,318	2,447	2,460	u	2,362	2,350
Nonmetro	325	413	495	531	549	555	521	440	449	448	u	348	330
Abortion rate	16.3	19.3	21.7	24.2	26.4	27.7	28.8	29.3	29.3	28.8	28.5	28.1	28.0
Abortion ratio†	193	220	249	265	286	294	297	300	301	300	304	297	298

*For 1973–1979, metropolitan status has been defined according to criteria published by the Office of Management and Budget (OMB), Oct. 1975. For 1980–1985, new definitions by the OMB based on the 1980 census have been used.

†For each year, the ratio is based on births occurring during the 12-month period starting in July of that year (to match times of conception for pregnancies ending in births with those for pregnancies ending in abortions).

Note: u = unavailable.

Sources: **Abortion and provider data**— For 1973–1982, see reference 1, Table 1. For 1983: estimate interpolated between 1982 and 1984 numbers. For 1984–1985, AGI abortion survey. **Population data**— For 1973–1982: see reference 1, Table 1. For 1983–1985: U.S. Bureau of the Census, "Estimates of the Population of the United States, by Age, Sex, and Race: 1980 to 1985," *Current Population Reports*, Series P-25, No. 985, 1986, Table 2. **Birth data**— For 1973–1980, see reference 1, Table 1. For 1981–1984: National Center for Health Statistics (NCHS), "Advance Report of Final Natality Statistics," *Monthly Vital Statistics Report*, Vol. 32, No. 9, Supplement, 1983 [for 1981]; Vol. 33, No. 6, Supplement, 1984 [for 1982]; Vol. 34, No. 6, Supplement, 1985 [for 1983]; and Vol. 35, No. 4, Supplement, 1986 [for 1984]. For 1985: NCHS, "Births, Marriages, Divorces and Deaths for June 1986," *Monthly Vital Statistics Report*, Vol. 35, No. 6, 1986.

ers, the abortion totals for 1984 and 1985 are probably about as accurate as those for previous years. Facilities for which no data could be obtained for 1984–1985 had provided about 22,000 abortions in 1982; the comparable figure in the previous survey had been 20,000.

In addition to missing facilities because they do not respond, the AGI surveys unavoidably overlook some providers, mainly small ones, because they have not been identified. The survey covering 1982 is believed to have undercounted the number of abortions performed in physicians' offices by 110,000.[1] This undercount, however, may have been partly offset by a tendency, noted in other surveys, for physicians to overestimate the number of abortions they provide. The latest estimate (made for 1978) of the number of uncounted hospital abortions is 800.[2] The number of clinic abortions not counted has not been estimated but is probably small, since identifying clinics that offer abortion services is relatively easy.

Typically, the number of abortions reported to the AGI has been higher than the number reported to the Centers for Disease Control (CDC), the other source of national data on abortion.[3] The CDC data for most states are based on summary information furnished by the state health departments, which may receive no information from some providers and incomplete information from others.* Therefore, the AGI figures for the nation as a whole and for most states are believed to be more accurate.

Numbers, Rates and Ratios

As Table 1 shows, the annual number of abortions rose steadily between 1973 and 1981 and then stabilized. In 1985, 1.59 million procedures were performed, a number not significantly different from the 1.58 million of 1984 or the 1.57 million of 1982.† In contrast, the number of abortion providers has declined significantly over the past few years: In 1985, there were 2,680 providers, eight percent fewer than in 1982. Even when the higher rate of nonresponse in the 1984–1985 survey is taken into account, a significant decrease of five percent is still evident.

The abortion rate of 28 per 1,000 women aged 15–44 in 1985 means that almost three percent of women of childbearing age had an abortion during the year. The rate has fallen from a high of 29 in 1981; the decline is almost exactly what one would expect to occur as a result of the decreasing proportion of 15–24-year-olds (the age-group with the highest abortion rate) within the population of women of reproductive age.

The abortion ratio of 298 for 1985 may be interpreted to mean that 30 percent of pregnancies not ending in miscarriage or stillbirth were terminated by abortion (the proportion is 25 percent when estimated miscarriages and stillbirths are taken into account). Since 1979, the abortion ratio has fluctuated within the narrow range of 297–304.

Geographic Availability

As Table 1 indicates, abortion services remain unavailable in many areas of the United States, particularly rural communities and small towns. Only 32,000 abortions, or two percent of the national total, were provided outside of metropolitan areas during 1985. Both the number and the proportion have fallen since the late 1970s, when almost five

Table 2. Percentage of counties with no abortion providers and with no providers reporting 400 or more abortions, and percentage of women aged 15–44 living in those counties, by metropolitan status,* 1985

Measure	Total	Metro	Nonmetro
Counties (N=3,135)			
With no provider	82	50	91
With no provider reporting ≥400 abortions	92	65	99
Women 15–44 (N=56,755,000)			
Living in counties with no providers	30	15	79
Living in counties with no provider reporting ≥400 abortions	43	26	98

*Defined according to criteria published by the OMB after the 1980 census.

*Not all states require the reporting of abortions. Moreover, states that do have reporting systems differ in the types of providers that must report, in the completeness of the information supplied, and in the follow-up performed by the states' health departments.

†There was no survey covering 1983. The figure that we estimated for 1983 in an earlier article—1.51 million—may have been too low. That estimate was based on trends in state health department reports, and the latest AGI survey data suggest that the completeness of the state reports has been decreasing. Our new estimate is 1.56 million. (See S. K. Henshaw, "Trends in Abortions, 1982–1984," *Family Planning Perspectives*, 18:34, 1986.)

percent of abortions took place in nonmetropolitan areas. Similarly, the number of providers located in nonmetropolitan areas has declined since 1978. Although some of the change may be an artifact of increased rates of nonresponse among small providers in the last few AGI surveys, the survey results suggest that services in nonmetropolitan areas have contracted.

Another measure of the availability of services is the proportion of counties with abortion providers. Women who live in counties that lack such facilities can travel to other jurisdictions, but the need to travel can impose substantial hardships, especially on teenagers and low-income women, and can be an insurmountable barrier. Eighty-two percent of U.S. counties have no identified providers of abortion services; these counties are home to 30 percent of all women aged 15–44 (see Table 2). Furthermore, in some of the counties that have providers, very few women obtain abortions, possibly because a local physician serves only his or her own established patients, or because the local physician or hospital is willing to provide abortions only under limited or rare circumstances. Therefore, the existence of a facility that provides 400 or more abortions per year (and so presumably can be easily located by potential patients) is a better indication of service availability than is just the presence of a provider.

As the table reveals, 92 percent of counties, where 43 percent of women live, have no such large-scale facility. Among nonmetropolitan counties, 99 percent have no large-scale providers, and 91 percent have no abortion providers at all. Seventy-nine percent of all nonmetropolitan women live in counties with no providers. While metropolitan counties are much better served, coverage is far from complete: Sixty-five percent have no providers that report at least 400 abortions per year, and half have none. No more than 40 abortions were performed in each of 81 of the nation's 305 standard metropolitan statistical areas (SMSAs) in 1985;* although most of these are small SMSAs, at least 400 abortions would have been performed in each if its abortion rate had approached the national average. Sixty-four of the 81 SMSAs had no identified abortion providers.

Since 1982, the proportion of counties with no providers has risen (from 78 percent to 82 percent), and the increase has occurred in both nonmetropolitan and metropolitan

*An SMSA consists of a county containing a city of 50,000 or more people, plus any surrounding metropolitan counties. All metropolitan counties are included in SMSAs. A list of the SMSAs having few or no abortion services is available from the authors.

Table 3. Number of reported abortions, rate per 1,000 women aged 15–44 and absolute change in rate, by state of occurrence, 1982, 1984 and 1985

State	Number of abortions			Abortion occurrence rate			
	1982	1984	1985	1982	1984	1985	Change, 1982–85
Total	**1,573,920**	**1,577,180**	**1,588,550**	**28.8**	**28.1**	**28.0**	**–0.8**
Ala.	19,930	19,210	19,380	21.6	20.3	20.2	–1.4
Alaska	1,930	3,170	3,450	17.0	26.2	27.7	+10.7
Ariz.	15,830	21,190	22,330	23.4	29.2	29.9	+6.5
Ark.	6,660	4,680	5,420	12.9	8.8	10.1	–2.8
Calif.	265,740	297,730	304,130	44.5	47.8	47.9	+3.4
Colo.	25,170	24,600	24,350	32.2	29.8	28.8	–3.4
Conn.	23,180	21,490	21,850	31.8	29.0	29.3	–2.5
Del.	3,870	4,710	4,590	26.5	31.8	30.9	+4.4
D.C.	28,630	23,690	23,910	169.9	142.9	145.9	–24.0
Fla.	76,910	75,800	76,650	34.8	32.3	31.8	–3.0
Ga.	38,480	38,710	38,340	27.7	26.8	26.1	–1.6
Hawaii	9,140	10,430	11,160	37.9	41.6	43.7	+5.8
Idaho	3,020	2,740	2,660	13.4	11.6	11.1	–2.3
Ill.	65,860	65,940	64,960	24.4	24.2	23.8	–0.6
Ind.	15,680	16,070	16,090	12.1	12.2	12.2	+0.1
Iowa	8,230	10,430	9,930	12.6	15.8	15.0	+2.4
Kans.	14,440	12,420	10,150	26.6	22.4	18.2	–8.4
Ky.	10,830	10,090	9,820	12.5	11.4	11.0	–1.5
La.	22,310	20,730	19,240	21.3	19.1	17.4	–3.9
Maine	5,470	5,180	4,960	21.1	19.6	18.6	–2.5
Md.	34,810	29,120	29,480	32.7	26.8	26.9	–5.8
Mass.	41,250	36,340	40,310	30.2	26.4	29.3	–0.9
Mich.	64,190	66,010	64,390	29.0	29.6	28.7	–0.3
Minn.	19,020	17,410	16,850	19.4	17.3	16.6	–2.8
Miss.	5,500	5,490	5,890	9.3	9.1	9.7	+0.4
Mo.	19,780	22,140	20,100	17.4	19.2	17.3	–0.1
Mont.	4,230	3,880	3,710	22.5	20.1	19.0	–3.5
Nebr.	6,580	6,730	6,680	18.3	18.4	18.2	–0.1
Nev.	9,960	9,370	9,910	46.0	39.8	40.5	–5.5
N.H.	5,600	6,740	7,030	24.5	28.3	29.0	+4.5
N.J.	61,080	65,860	69,190	35.7	37.9	39.6	+3.9
N.Mex.	7,470	5,380	6,110	22.8	15.6	17.4	–5.4
N.Y.	182,700	192,020	195,120	44.5	46.6	47.4	+2.9
N.C.	33,230	35,800	34,180	23.0	24.0	22.6	–0.4
N.Dak.	3,350	2,940	2,850	22.4	19.3	18.5	–3.9
Ohio	61,440	58,040	57,360	24.3	22.7	22.4	–1.9
Okla.	12,690	12,630	13,100	17.6	16.8	17.1	–0.5
Oreg.	16,350	15,310	15,230	25.2	22.8	22.3	–2.9
Pa.	64,060	60,680	57,370	24.1	22.6	21.3	–2.8
R.I.	7,770	7,450	7,770	35.8	34.1	35.5	–0.3
S.C.	16,140	11,260	11,200	20.7	14.0	13.7	–7.0
S.Dak.	1,770	1,770	1,650	11.6	11.4	10.6	–1.0
Tenn.	26,100	22,570	22,350	23.3	19.5	19.1	–4.2
Tex.	105,820	99,960	100,820	29.2	26.0	25.5	–3.7
Utah	4,180	4,240	4,440	11.4	10.9	11.1	–0.3
Vt.	3,710	3,450	3,430	29.4	26.7	26.2	–3.2
Va.	34,880	31,670	34,180	25.7	22.6	24.0	–1.7
Wash.	34,130	29,510	30,990	32.9	27.2	28.0	–4.9
W.Va.	3,420	4,680	4,590	7.7	10.4	10.1	+2.4
Wis.	20,380	18,640	17,830	18.5	16.6	15.7	–2.8
Wyo.	1,020	1,060	1,070	8.4	8.1	7.9	–0.5

Notes: In this and subsequent tables, numbers of abortions are rounded to nearest 10. Rates are based on population estimates for July 1 of each year; estimates have been made by interpolating between 1980 census data and unpublished population estimates for 1985 provided by Market Statistics, New York.

Table 4. Number of abortions by state of occurrence, and number and percentage provided to nonresidents; number of abortions by woman's state of residence, and number and percentage obtained out of state; and resident abortion rate per 1,000 women 15–44; 1982

State	Abortions by state of occurrence			Abortions by woman's state of residence			Resident abortion rate
	Total	Obtained by nonresidents		Total	Obtained out of state		
		No.	%		No.	%	
Total	**1,573,920**	**110,150**	**7**	**1,565,030***	**101,260***	**6**	**28.6**
Ala.	19,930	1,300	7	20,470	1,840	9	22.1
Alaska	1,930	0	0	2,350	420	18	20.7
Ariz.	15,830	530	3	15,960	660	4	23.5
Ark.	6,660	240	4	8,270	1,850	22	16.0
Calif.	265,740	1,260	†	266,370	1,890	1	44.5
Colo.	25,170	1,810	7	23,620	260	1	30.2
Conn.	23,180	490	2	24,610	1,920	8	33.7
Del.	3,870	840	22	3,730	700	19	25.5
D.C.	28,630	13,950	49	15,390	710	5	91.1
Fla.	76,910	3,390	4	74,070	550	1	33.5
Ga.	38,480	3,950	10	37,260	2,730	7	26.8
Hawaii	9,140	70	1	9,080	10	†	37.6
Idaho	3,020	210	7	3,460	650	19	15.3
Ill.	65,860	2,120	3	67,790	4,050	6	25.1
Ind.	15,680	490	3	20,490	5,300	26	15.8
Iowa	8,230	820	10	9,290	1,880	20	14.2
Kans.	14,440	5,530	38	9,670	760	8	17.8
Ky.	10,830	4,230	39	9,710	3,110	32	11.2
La.	22,310	2,080	9	23,730	3,500	15	22.6
Maine	5,470	820	15	5,410	760	14	20.9
Md.	34,810	2,080	6	43,130	10,400	24	40.4
Mass.	41,250	1,650	4	42,670	3,070	7	31.2
Mich.	64,190	1,930	3	63,270	1,010	2	28.5
Minn.	19,020	2,350	12	17,450	780	4	17.7
Miss.	5,500	390	7	8,020	2,910	36	13.6
Mo.	19,780	2,750	14	22,730	5,700	25	20.0
Mont.	4,230	960	23	3,440	170	5	18.3
Nebr.	6,580	1,440	22	5,650	510	9	15.7
Nev.	9,960	1,610	16	8,720	370	4	40.3
N.H.	5,600	1,570	28	4,780	750	16	20.9
N.J.	61,080	1,340	2	65,630	5,890	9	36.3
N.Mex.	7,470	270	4	8,960	1,760	20	27.3
N.Y.	182,700	9,480	5	175,230	2,010	1	42.6
N.C.	33,230	1,950	6	33,320	2,040	6	23.0
N.Dak.	3,350	1,860	56	1,740	250	14	11.6
Ohio	61,440	3,210	5	60,310	2,080	3	23.6
Okla.	12,690	750	6	15,380	3,440	22	21.4
Oreg.	16,350	970	6	16,240	860	5	25.0
Pa.	64,060	4,080	6	64,010	4,030	6	24.0
R.I.	7,770	2,010	26	6,150	390	6	28.3
S.C.	16,140	1,030	6	17,570	2,460	14	22.5
S.Dak.	1,770	510	29	1,810	550	30	11.8
Tenn.	26,100	4,890	19	23,000	1,790	8	20.5
Tex.	105,820	9,420	9	98,030	1,630	2	27.0
Utah	4,180	250	6	4,150	220	5	11.3
Vt.	3,710	960	26	3,060	310	10	24.2
Va.	34,880	2,030	6	38,500	5,650	15	28.3
Wash.	34,130	3,040	9	32,140	1,050	3	31.0
W.Va.	3,420	610	18	5,350	2,540	47	12.1
Wis.	20,380	610	3	21,510	1,740	8	19.5
Wyo.	1,020	20	2	2,350	1,350	57	19.3

*Excludes an estimated 8,890 nonresidents of the United States who obtained abortions in the United States.

†Fewer than 0.5 percent.

Sources: **Number of abortions**—AGI survey and unpublished data compiled by the Centers for Disease Control. **Number of women**—see notes to Table 3.

counties (from 87 percent to 91 percent in the former, and from 47 percent to 50 percent in the latter). At the same time, the number of metropolitan counties with no large providers has declined (from 67 percent to 65 percent). Thus, the decline in abortion availability has been concentrated in counties having only a few providers with small caseloads. Some of the decline is an effect of nonresponse to the 1984–1985 AGI survey, but for the most part it stems from a trend toward the provision of services in abortion clinics, which are concentrated in the larger cities. That trend will be discussed in a later section.

The uneven geographic distribution of abortion services is reflected in the widely varying state abortion rates shown in Table 3 (see page 65). In 1985, the highest rate, 48 abortions per 1,000 women aged 15–44, in California,* was six times the lowest rate, eight per 1,000, in Wyoming. Some of the difference may have been due to the higher rate of unintended pregnancy in California. However, there is abundant evidence that the local availability of abortion services has an important effect on the utilization rate;[4] therefore, a low abortion rate may be attributable in part to inadequate services. Besides Wyoming, states with abortion rates under 12 are Arkansas, Mississippi and West Virginia (10 per 1,000), and Idaho, Kentucky, South Dakota and Utah (11 per 1,000). These are predominantly rural states, large areas of which lack abortion services. In addition to California, the states with the highest abortion rates are New York (47), Hawaii (44), Nevada (41) and New Jersey (40). In general, rates are higher on the East and West Coasts than in the interior states.

Until 1982, state abortion rates appeared to be converging, with the highest rates declining (Nevada's, for example) and the lowest rising (South Dakota's). The convergence reflected in part the widening availability of abortion facilities. There has been no additional convergence of rates since 1982, further evidence that the availability of abortion services has stopped increasing.

Table 3 shows the changes in the abortion rates between 1982 and 1985. (Because such changes can be strongly influenced by small errors in the data, they should be interpreted with caution. Errors can be introduced by incomplete or inconsistent reporting of abortions and by inaccurate estimates of the size

*The highest rate in 1985 was actually the District of Columbia's. However, it is not comparable to the state rates because it applies only to the central city of a large urban area. Central cities typically have high abortion rates among residents and, in addition, are the location of abortion services for many women from surrounding areas.

of the female population aged 15–44.) The largest change is a 24-point decline in the abortion rate of the District of Columbia; the decrease reflects in part the closing of one clinic and a reduction in the caseloads of two other facilities. Although we know of no deficiencies in the data for the District, such a large drop raises questions about the accuracy of the information. The 11-point increase in Alaska reflects the opening of a clinic in a previously unserved area. Similarly, a new clinic accounts for the four-point increase in Delaware. For other states, no specific factors are known that account for observed changes.

Each of the southern census divisions—South Atlantic, East South Central and West South Central—registered declines of 2–3 points. The Middle Atlantic and Pacific divisions are the only two that experienced increases in their abortion rates. (Not shown.)

Another measure of the uneven distribution of abortion facilities is the number of women who travel out of state for abortion services. (Interstate travel is particularly common among women who need second-trimester abortions.) In 1982, the latest year for which we have data, six percent of abortions nationwide were performed outside the woman's home state (see Table 4). The proportion was as high as 57 percent for Wyoming residents and 47 percent for those of West Virginia, and was more than 25 percent for the residents of four other states—Indiana, Kentucky, Mississippi and South Dakota. Because of the scarcity of abortion providers in these states and the need to travel long distances for services, some state residents were probably deterred from obtaining abortions, as is evidenced by the relatively low abortion rates even when out-of-state abortions are taken into account. The amounts and patterns of interstate travel for abortion services changed little between 1981 and 1982.

The abortion rates in the last column of Table 4 reflect abortions obtained by state residents, regardless of the place of occurrence. They are therefore better measures of abortion use than are occurrence rates. In the District of Columbia, the 1982 residence rate of 91 is much lower than the 1982 occurrence rate of 170 because many women from Maryland and Virginia go to Washington, D.C., for abortions. In Kansas, North Dakota and Rhode Island, the residence rates are eight or more points lower than the occurrence rates because of the numbers of out-of-state women served. Maryland, Wyoming and several other states, meanwhile, have higher residence than occurrence rates because many of their residents obtain abortions in other states.

Table 5. Number and percentage distribution of abortions and abortion providers, by type of facility, according to caseload, 1985

Caseload*	Total		Hospitals		Abortion clinics		Other clinics		MDs' offices†	
	No.	%	No.	%	No.	%	No.	%	No.	%
Abortions	**1,588,550**	**100**	**207,950**	**13**	**953,480**	**60**	**361,860**	**23**	**65,260**	**4**
<30	6,790	‡	4,720	‡	0	0	200	‡	1,870	‡
30–390	150,030	9	61,940	4	1,890	‡	22,810	1	63,390	4
400–990	205,310	13	55,730	4	35,090	2	114,490	7	na	na
1,000–4,990	919,360	58	68,220	4	652,630	41	198,510	12	na	na
≥5,000	307,060	19	17,340	1	263,870	17	25,850	2	na	na
Providers	**2,680**	**100**	**1,191**	**44**	**399**	**15**	**438**	**16**	**652**	**24**
<30	687	26	517	19	0	0	16	1	154	6
30–390	1,174	44	544	20	9	‡	123	5	498	19
400–990	320	12	92	3	50	2	178	7	na	na
1,000–4,990	455	17	36	1	302	11	117	4	na	na
≥5,000	44	2	2	‡	38	1	4	‡	na	na

*In this and subsequent tables, caseloads are rounded to nearest 10.

†In this and subsequent tables, physicians' offices reporting 400 or more abortions a year are classified as clinics (either abortion or other clinics).

‡Fewer than 0.5 percent. Note: na = not applicable.

The number of residents of other countries who obtained abortions in the United States is estimated at 9,000—5,400 from Canada, 2,000 from Mexico and the remainder mainly from countries in the Caribbean area.

Service Providers

Abortions are performed in hospitals (as inpatient and outpatient procedures), abortion clinics, other kinds of clinics (such as surgicenters) and private physicians' offices. When abortion was legalized nationally, in 1973, most procedures were done in hospitals; but over the years, there has been a pronounced movement toward nonhospital facilities. As Table 5 illustrates, this trend continued in 1985, when only 13 percent of abortions (208,000) took place in hospitals—down from 14 percent in 1984 and 18 percent in 1982 (not shown). The change is the result of a reduction in both the number of hospitals offering abortion services and the average number of abortions performed in each hospital.

The long-term trend away from hospital abortions is due mainly to the cost advantages of nonhospital settings. Even when abortions are performed as day procedures (not requiring an overnight stay), hospital charges are generally much higher than those typical of nonhospital facilities. A 1982 study found that the charge (including the physician's fee) for a first-trimester outpatient abortion in the average hospital was $735, compared with about $190 (in 1981) for a clinic abortion.[3] Furthermore, whereas in the past some insurance policies covered hospital but not clinic procedures, insurance companies have increasingly been restricting their coverage of hospital abortions to procedures that cannot be performed elsewhere. In addition, second-trimester abortions have become more available outside hospitals, making hospitalization medically necessary only for patients undergoing instillation abortions or concurrent surgical procedures, and for patients with preexisting medical conditions.

Along with the general shift away from hospitals has come a rapid movement within the hospital setting away from inpatient and toward outpatient abortion services, which are generally less expensive and more convenient for the patient. Thirty-three percent of hospital abortions were performed as inpatient procedures during 1982, compared with 24 percent in 1984 and 21 percent in 1985. Thus, of all abortions, only three percent involve actual hospitalization. Eighty percent of hospitals that provide abortions permit them to be done as outpatient procedures; as recently as 1980, only 55 percent did so.

Although the number of abortions performed in hospitals has declined, these facilities are still important in making services available. In many U.S. counties, a hospital is the only facility where an abortion can be obtained. Physicians in small communities may judge that existing demand does not justify their equipping their offices to provide abortion services, and such doctors may, therefore, prefer to use hospital facilities. Some doctors also believe that the procedure is more safely performed in a hospital than in their private offices. In addition, hospitals are needed for instillation abortions and for high-risk patients.

Table 6. Number of abortion providers in 1982 and 1985, and change between 1982 and 1985, by type of facility

Type of facility	1982	1985	Change	
			No.	%
Total	**2,908**	**2,680**	**−228**	**−8**
Hospitals	**1,405**	**1,191**	**−214**	**−15**
Public	331	265	−66	−20
Federal	4	0	−4	−100
State	43	40	−3	−7
Hospital district	135	100	−35	−26
County	88	74	−14	−16
City; city/county	61	51	−10	−16
Private	1,074	926	−148	−14
Voluntary, church	63	50	−13	−21
Voluntary, other	806	702	−104	−13
Proprietary	205	174	−31	−15
Nonhosp. facil. by caseload	**1,503**	**1,489**	**−14**	**−1**
Clinics	789	837	+48	+6
<30	14	16	+2	+14
30–390	118	132	+14	+12
400–990	218	228	+10	+5
≥1,000	439	461	+22	+5
MDs' offices	714	652	−62	−9
<30	180	154	−26	−14
30–390	534	498	−36	−7

In 1985, as Table 5 shows, abortions were performed in at least 1,191 hospitals. (The actual number is slightly greater, since some hospitals were reluctant to provide any information, even on a confidential basis.) Hospitals thus constituted 44 percent of all known abortion providers, but they were responsible for only 13 percent of the procedures performed in 1985. Hospital providers tend to have small abortion caseloads: Forty-three percent reported fewer than 30 procedures in 1985, and only three percent reported 1,000 or more.

The nonhospital facilities shown in Table 5 are divided into three categories: abortion clinics, other clinics and physicians' offices. The category "physicians' offices" consists of practices providing fewer than 400 procedures in 1985; practices with larger abortion caseloads (at least 400 procedures in 1985) are grouped with the clinics because they resemble the latter facilities in many respects. "Abortion clinics" are clinics (regardless of caseload) and larger physicians' practices reporting that at least 50 percent of their patients' visits were made for the purpose of abortion.* "Other clinics" are those facilities and larger physicians' practices not meeting that criterion.

*Clinics and physicians' offices that did not provide information about the percentage of patient visits made for abortion were classified as abortion clinics if they reported 1,000 or more abortions (clinics) or 1,500 or more abortions (physicians' offices).

Although the 399 abortion clinics made up only 15 percent of providers in 1985, they accounted for 60 percent of all abortions. Eighty-five percent (340) of these clinics reported 1,000 or more procedures. The 438 other (nonabortion) clinics provided 23 percent of all abortions; 28 percent of these facilities provided 1,000 or more abortions each. Almost 25 percent of the providers were physicians' offices, but they accounted for only four percent of all abortions; however, this proportion about doubles when the estimated number of office procedures missed by the survey is included.

Of all abortions performed in 1985, three-quarters took place in facilities having annual abortion caseloads of at least 1,000. The two percent of providers that had caseloads of 5,000 or more were responsible for one-fifth of all abortions.

Since 1977, when a peak of 1,654 hospitals offered abortion services, the number of hospital providers has been declining. As Table 6 shows, between 1982 and 1985 the number of known hospital providers dropped by 15 percent. The reduction was somewhat larger among public facilities than among private ones (20 percent vs. 14 percent). Of the public hospitals other than federal facilities (for which the data are incomplete), hospital-district facilities showed the greatest decline, and state hospitals, the smallest decline. Hospital districts, which are controlled by cooperating jurisdictions, are usually located in smaller cities and rural areas; state hospitals are generally associated with state medical schools. Within the private sector, the decline in hospital providers was greatest among church-affiliated institutions.

The change in the number of hospital providers was the net result of some providers' discontinuing services and some facilities' offering services for the first time. The change was greatest among providers with small caseloads: Of the hospitals that performed fewer than 30 abortions in 1982, 37 percent no longer performed abortions in 1985. (This rate of discontinuation is higher than that of 30 percent found between 1980 and 1982; the difference may be attributable to the longer time span between 1982 and 1985 than between 1980 and 1982.) Among hospitals that provided larger numbers of abortions in 1982, the discontinuation rate was much lower: eight percent of facilities reporting 30–390 abortions, three percent of those performing 400–990 and two percent of those reporting 1,000 or more. These percentages are not much different from those observed in 1982 among 1980 providers, although we would have expected them to be higher.

A large part of the decline in hospital providers occurred because the number of new hospital providers identified in 1985 was lower than the number found in 1982 (95 compared with 142), even though a larger number might have been expected as a result of the longer time span involved (1982–1985 vs. 1980–1982). Of the hospital providers lost by 1985 and not replaced by new providers, almost all had been performing fewer than 30 abortions a year.

In 1985, the 1,191 hospitals that provided abortions constituted only 21 percent of the country's 5,732 short-term general hospitals; the proportion is 23 percent when Catholic hospitals are excluded. Private non-Catholic general hospitals were more likely to offer services than were public hospitals—26 percent compared with 17 percent.[6]

As the table shows, the number of nonhospital facilities declined slightly between 1982 and 1985. The number of physicians' offices reporting abortions dropped by nine percent, but this decrease was almost balanced by an increase in other nonhospital facilities.

As with the rate among hospitals, the 1982–1985 discontinuation rate among nonhospital providers was greatest for the smallest facilities: It ranged from 37 percent of those reporting fewer than 30 abortions in 1982 to seven percent of those performing 1,000 or more. These proportions are about 50 percent higher, on average, than the proportions of 1980 providers that had terminated services by 1982, but such a difference is to be expected, given the lengths of the two observation periods. Between 1982 and 1985, the number of nonhospital providers that initiated abortion services was greater than the number that discontinued them, in all caseload categories except the smallest (fewer than 30 abortions annually). Most of the smallest providers are physicians' offices.

Gestation

The existence of a provider in a locality does not guarantee that all women needing abortions will be able to obtain them. One difficulty faced by some women is the need to find a facility that will perform the procedure after the 12th week of pregnancy. A substantial number of women who terminate their pregnancies (10 percent in 1983) do so after 12 weeks—some because they have been late in recognizing they are pregnant or have medical reasons for delaying, and others because they have faced geographic, financial or other obstacles. A disproportionate number of women who obtain second-trimester abortions are teenagers.[7]

Table 7 shows that 57 percent of providers do not perform abortions when a woman is more than 12 weeks from her last menstrual period (LMP); 11 percent do not provide services past eight weeks. Abortion clinics

are far more likely to offer second-trimester procedures than are other providers—75 percent, compared with 46–50 percent of other clinics and hospitals and 13 percent of physicians' offices. These differentials are to be expected, since providers with smaller caseloads may not find it worthwhile to undergo or institute the additional training needed to perform second-trimester abortions.

Since 1982, the proportion of providers offering services after 12 weeks LMP has increased substantially, from 33 percent to 43 percent. The increase has been especially great among abortion clinics—from 58 percent to 75 percent. One of the factors contributing to the change was a 1983 Supreme Court ruling that states may not require early second-trimester abortions to be performed in hospitals. Several federal court rulings have since found bans on nonhospital abortions during the middle of the second trimester to be similarly unconstitutional.

Abortion Charges and Subsidies

Since women who obtain abortions usually must pay for them with cash in advance,* the cost may be an important barrier for poor women and for teenagers. As of mid-1986 (when the survey questionnaire was filled out), the average amount paid for a nonhospital abortion performed at 10 weeks LMP with local anesthesia was $213 (see Table 8). Many women pay more than that amount, some because their abortions are performed at later gestations, and many others because of additional costs for transportation, extra lab tests and medication needed in certain cases, and other miscellaneous expenses. The income that some women lose because of time missed from work should also be figured in to the cost of an abortion. On the other hand, the average cost does not take into account either the state funds for abortions for low-income women that are available in 14 states and the District of Columbia, or the reduced rates offered by some facilities to certain low-income women.

Table 7. Percentage distribution of abortion providers, by maximum gestation (weeks LMP) at which they perform abortions, according to type of provider, 1985

Weeks LMP	Total* (N = 1,803)	Hospitals (N = 645)	Abortion clinics (N = 330)	Other clinics (N = 348)	MDs' offices (N = 482)
5–6	2	2	0	†	4
7–8	9	9	1	2	17
9–10	12	9	4	10	26
11–12	34	34	20	38	40
13–14	11	6	21	21	7
15–16	8	5	21	13	3
17–20	17	26	21	13	2
≥21	7	9	12	3	1
Total	100	100	100	100	100

*Standardized to actual percentage distribution of abortion providers, to account for differences in response rates by type of provider.

†Fewer than 0.5 percent.

Table 8. Mean charge and range of charges in 1986 for a nonhospital abortion at 10 weeks LMP with local anesthesia, by 1985 caseload; and mean amount paid; according to type of facility

Measure and caseload	Total	Abortion clinics	Other clinics	MDs' offices
Mean amount charged*	**$238 (992)**	**$209 (336)**	**$235 (324)**	**$272 (332)**
<30	306 (52)	0 (0)	310 (6)	306 (46)
30–399	266 (369)	192 (8)	275 (75)	266 (286)
400–999	223 (178)	214 (47)	226 (131)	na
1,000–4,999	211 (355)	209 (247)	216 (108)	na
≥5,000	203 (38)	204 (34)	191 (4)	na
Range	75–897	100–615	100–897	75–650
Mean amount paid†	**$213 (1,186,000)**	**$208 (615,000)**	**$219 (312,000)**	**$260 (39,000)**

*Averaged over the number of facilities (shown in parentheses).

†Averaged over the number of abortions (shown in parentheses).

Note: na = not applicable.

As Table 8 shows, facilities with larger caseloads have lower average charges, evidently reflecting economies of scale. Facilities that provide 5,000 or more abortions charge a mean of $203, whereas those with caseloads under 30 charge $306. Abortion clinics tend to charge somewhat less than do other types of clinics and doctors' offices.

Charges for a first-trimester abortion range from $75 to almost $900. Since most women utilize facilities at the lower end of the cost spectrum, the average amount they pay ($213) is less than the amount charged by the average facility ($238).

In facilities that offer a choice of local or general anesthesia, the latter costs an additional $107, on average (not shown). The charge for general anesthesia is lowest in abortion clinics ($67) and highest in physicians' offices ($181). Only a minority of facilities offer general anesthesia: 37 percent of abortion clinics, 25 percent of other clinics, 13 percent of physicians who perform abortions in their offices, and 26 percent of all nonhospital providers combined.

The cost of abortion services has risen less rapidly than has the cost of other types of medical care. Between 1983 and 1986, the average amount paid for a first-trimester nonhospital abortion rose by seven percent, from $200 to $213,[8] while the consumer price index for medical care rose by 21 percent.[9] Price increases were about the same in both groups of clinics and physicians' offices.

The average amount paid for an abortion varies significantly by state. Most expensive, averaging $300 or more, are services in Alaska, Hawaii and South Dakota. Other states with relatively high average costs (over $240) are Idaho, Iowa, North Dakota, Oklahoma, Utah and Wyoming. Most of these are less-urbanized states, where community pressures may make it difficult for facilities to offer abortion services and where there are few providers to stimulate competition. Women pay less than $190, on average, in Delaware, Nevada, Oregon, Virginia and Washington, plus the District of Columbia. (The average is also below $190 in Rhode Island, but price information is available from only two facilities.)

The relatively few women who obtain abortions from nonhospital facilities in nonmetropolitan areas pay an average of $37 more than do women who utilize such facilities in metropolitan areas. Nonmetropolitan facilities tend to have small abortion caseloads, but the cost differential remains even when caseload is controlled for.

Low-income women have two main sources of help in paying for abortions: public funding through the Medicaid mechanism, and providers who are willing to offer services at reduced fees or no charge. Since 1977, virtually no federal Medicaid funds have been used to subsidize abortions; and only a minority of states have used their own monies to fund abortions. In 1985, 14 states† and the District of Columbia covered the cost of some 187,500 abortions obtained by indigent women.[10] Those procedures amounted to 22 percent of abortions provided in all facilities, including hospitals, in those states. (Since 1982, public funding for abortions has

*Few women use insurance to pay for abortions. See S. K. Henshaw and L. S. Wallisch, "The Medicaid Cutoff and Abortion Services for the Poor," *Family Planning Perspectives*, 16:170, 1984.

†Alaska, California, Connecticut, Hawaii, Maryland, Massachusetts, Michigan, New Jersey, New York, North Carolina, Oregon, Vermont, Washington and West Virginia.

Table 9. Percentage of nonhospital abortion providers that accept state payments for at least two percent of their abortion payments, and percentage of abortions paid for with state funds, in all states and in funding states; percentage of nonhospital providers that offer reduced fees, and percentage of abortions provided at reduced fee; by type of provider, 1985

Measure	Total (N = 831)	Abortion clinics (N = 244)	Other clinics (N = 258)	MDs' offices (N = 329)
State funds				
Providers accepting for ≥2% of patients				
All states	39	29	52	37
Funding states	73	75	85	61
Abortions paid for*				
All states	10	8	11	11
Funding states	19	17	22	17
Reduced fee†				
Providers offering to ≥2% of patients	55	59	59	49
Abortions provided at reduced fee*	7	6	9	9

*Weighted by the number of abortions provided. †Includes abortions provided without charge.

been terminated by Colorado and Pennsylvania and has been instituted by Vermont.) Even when the state covers abortions, not every provider will accept the state's reimbursement, which is usually lower than the provider's customary fee, involves extra paperwork and may be delayed.

Table 9 illustrates the degree to which abortion services are subsidized. Thirty-nine percent of nonhospital providers accept public funding for at least two percent of their abortion patients. The proportion accepting state reimbursement is lower among abortion clinics (29 percent) and physicians' offices (37 percent) than among other clinics (52 percent). When the analysis is limited to providers in states that fund abortions for poor women, the overall proportion rises to 73 percent, but it remains lower among abortion clinics and private doctors than among other clinics. Nonhospital facilities in funding states report that 19 percent of the abortions they provide are paid for by the state.

As these statistics indicate, state abortion funding is a major source of income for relatively few facilities. Only one-fourth of the abortion clinics located in the funding states report that 25 percent or more of their patients rely on the state to pay for their abortions. The proportion of other clinics is slightly higher—one-third—but since most of the services they provide are not abortion-related, these facilities are not dependent on state abortion funds for a large part of their income. (Not shown.)

Low-income patients unable to obtain publicly funded coverage for their abortions can sometimes obtain services at reduced cost or, more rarely, at no cost. Table 9 shows that 55 percent of nonhospital providers offer some reduction in charges to at least two percent of their patients. On average, seven percent of all patients in nonhospital facilities are charged reduced fees. Private doctors and clinics that do not specialize in abortion are more generous in allowing reduced rates than are abortion clinics.

Discussion

Some important changes have occurred in the provision of abortion services in recent years. Since 1982, the number of hospital abortion providers has continued its long-term decline, and the pace of that decline has accelerated. The principal reasons for the shift to nonhospital facilities are undoubtedly the lower cost and greater convenience of clinic abortions. However, the pattern of change in the number of providers raises the question of whether antiabortion pressures may also have played a role. The decline in hospital facilities was greatest among those controlled by hospital districts and among church-affiliated institutions. One might expect these types of hospitals to be especially subject to pressure, the former because they tend to be located in small towns, where antiabortion sentiment is likely to be strong, and the latter because many religious groups have strong antiabortion factions. If in fact antiabortion activity has had an effect, it evidently has been at least as much by preventing hospitals from initiating abortion services as by forcing those providing services to stop. Any such effect has been on small providers only; there is no statistical evidence that hospitals providing 30 or more abortions a year have been induced to stop.

The number of private doctors providing abortions to relatively small numbers of patients has also decreased since 1982. The reduction in the number of hospital and physician providers has been particularly pronounced in nonmetropolitan areas. The proportion of nonmetropolitan counties with services, while always low, has fallen to just nine percent, and the proportion of abortions performed in nonmetropolitan areas is at a new low of 2.0 percent. Small cities have been affected as well, as indicated by the increase (from 72 to 81) in the number of SMSAs reporting few or no abortions.

The cutoff of state funding of abortion in Colorado and Pennsylvania, only partly offset by new state funding in Vermont, has also reduced access to abortion services.

In two respects, however, access has improved since 1982. The number of nonhospital providers serving 400 or more women a year has increased slightly, and a larger proportion of urban counties now have such a provider. Perhaps more important, a larger proportion of abortion facilities now perform second-trimester procedures, making services available to more of the women who need later pregnancy terminations.

Despite the changes in the pattern of service availability between 1982 and 1985, the abortion rate has remained stable. Possibly the loss of services in nonmetropolitan areas has been offset by the improvements that have occurred.

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Characteristics of U.S. Women Having Abortions, 1982–1983

By Stanley K. Henshaw

Summary

In 1982 and 1983, as in previous years, the majority of abortions in the United States were obtained by young women (62 percent), white women (70 percent) and unmarried women (81 percent). Half of all abortions were performed eight or fewer weeks after the last menstrual period, and 91 percent, at 12 weeks or earlier. The proportion of abortions that were repeat procedures continued to rise, to 37 percent in 1982 and 39 percent in 1983.

The rate of abortion, 29 per 1,000, has remained essentially the same since 1981. Women aged 18–19 continue to have the highest abortion rate of any age-group (60 per 1,000). While most abortions are obtained by white women, the nonwhite abortion rate is more than twice that of whites.

Thirty percent of all pregnancies were terminated by abortion in 1983, the same proportion as in 1982 and 1981. The highest abortion ratios are found among unmarried women (63 percent), women 40 and older (51 percent), teenagers (42 percent) and nonwhites (40 percent). Teenage nonwhites and whites have about the same abortion ratios.

After rising during the 1970s, the adolescent pregnancy rate peaked around 1980–1981 and fell slightly in 1982–1983. The relative differentials between the pregnancy, birth and abortion rates of nonwhite and white teenagers narrowed somewhat between 1978 and 1981, but then widened slightly between 1981 and 1983.

Introduction

As part of its program of monitoring abortion services in the United States, The Alan Guttmacher Institute (AGI) periodically updates statistics on the demographic characteristics of women who have abortions, on the stages of gestation at which abortions are performed, and on the types of procedures used. The previous report of these statistics covered 1980–1981.[1]

The data presented below have been estimated by applying the percentage distributions of abortions according to various characteristics—as determined for each year by the Centers for Disease Control (CDC) abortion surveillance system—to the total number of abortions estimated by the AGI. The percentage distributions obtained from the CDC data have been adjusted to remove the influence of extraneous year-to-year changes in the data (for example, changes in the particular states included in the CDC compilation). The total numbers of abortions come from the AGI's periodic national surveys of all abortion providers identified in the United States. The figure for 1982 comes from the survey conducted in that year; the total for 1983 is based on a preliminary analysis of the 1984–1985 provider survey. A detailed description of the methodology used and the statistics computed for each year from 1973 to 1981 may be found in an earlier publication.[2]

In addition to demographic breakdowns, this article presents abortion rates and ratios, which permit examination of trends and subgroup differences in abortion utilization. The population estimates used in computing the abortion rates come from the Census Bureau; the numbers of births used in calculating the abortion ratios are from the National Center for Health Statistics (NCHS).

Findings

Table 1 (page 6) shows the number and percentage distribution of abortions performed in 1982 and 1983 by selected characteristics of the women. In both years, 1.57 million procedures were performed. This stability in the number is inconsistent with earlier estimates, based on other data, that had suggested a decline in the number of abortions after 1982.[3]

As in previous years, a majority of the women obtaining abortions in 1982–1923 were young: Some 62 percent were under age 25, while only 17 percent were 30 and older. About 27 percent of abortion patients were teenagers and one percent were younger than 15.

Nonwhite women accounted for 30 percent of abortions in 1982 and 31 percent in 1983. The proportion of abortions obtained by nonwhite women has risen slowly since 1979, when it was at a low of 29 percent, but it has yet to equal its earlier peak of 33 percent, reached in 1976. Unmarried women (those never-married, separated, divorced or widowed) accounted for 81 percent of abortion procedures in 1983, the same proportion as in 1982 and 1981. Prior to 1981, the proportion unmarried among women undergoing abortion increased by one percentage point per year, on average.

About 57 percent of abortion patients in 1982–1983 were nulliparous, suggesting that the procedure is generally used by women to delay childbearing. The proportion childless has been fairly constant at 57–58 percent since 1978. Eight percent of women having an abortion in 1983 had borne three or more children, unchanged from 1982.

Thirty-seven percent of abortion patients in 1982, and 39 percent in 1983, had previously had at least one abortion; 12 percent and 13 percent, respectively, had had two or more abortions. The proportion of patients with prior abortion experience has risen every year since 1974, when it was 15 percent. The increase reflects the growing number of women in the population who have had an abortion in the past and who therefore are at risk of having a second or higher order abortion.[4] If the abortion rate remains at about its present level, the increase in repeat abortions will probably continue for the next few years and then stabilize.

In 1982 and 1983, half of all procedures took place eight or fewer weeks after the last

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menstrual period (weeks LMP); the data suggest a slight decline since 1980, when the figure was 52 percent. The proportion performed after 12 weeks has remained at approximately nine percent since 1977, after having fallen sharply between 1973 and 1977 (from 15 percent). One percent of abortions in both 1982 and 1983 were performed past 20 weeks; however, the 1983 number (slightly more than 12,000) was down sharply from the number in 1982 (just over 14,000). Special tabulations for single weeks of gestation after 20 weeks have been made using NCHS data on more than 300,000 abortions in 13 states during 1983; the gestation measure used is the physician's postoperative estimate.* The tabulations indicate that of the abortion procedures performed after 20 weeks, 60 percent were done at 21 or 22 weeks' gestation; only about 100 abortions (or 0.01 percent of all procedures) were performed after 24 weeks.

The use of instrumental evacuation (vacuum aspiration, also called suction curettage; dilatation and curettage; and dilatation and evacuation) continued its long-term increase, reaching 97 percent in 1982 and 1983. Of instrumental evacuations during the first trimester, 95 percent were performed by vacuum aspiration (not shown). Medical induction, usually by intrauterine instillation of saline or prostaglandin, decreased correspondingly and now is used for only three percent of procedures. Abortion by hysterectomy or hysterotomy, performed in fewer than 0.1 percent of cases, has practically disappeared.

Table 2 shows patterns of abortion use, as measured by abortion rates and ratios among women of differing ages, racial groups and marital statuses. In 1983, the abortion rate was highest among women aged 18–19 and 20–24 (60 and 51 per 1,000 women, respectively), nonwhite women (56 per 1,000) and unmarried women (48 per 1,000). Of all the demographic subgroups shown, women 40 and older had the lowest rate (three per 1,000), followed by women aged 35–39 and those under 15 (10 and nine per 1,000, respectively).

The table also shows trends in abortion use between 1981 and 1983. The overall rate of abortion, 29 per 1,000, has stayed essentially the same since 1981, as have the rates for all the subgroups shown. In 1983, as in 1981, the rate was more than twice as high for nonwhites as for whites; and it was nearly five times as high for unmarried women as for married women.

The total abortion rate in both 1981 and 1983 was 790 (not shown), meaning that given present age-specific rates, a cohort of 1,000 women will have had 790 abortions by the end of their reproductive lives. This rate represents four abortions for every five women.

The abortion ratios presented in Table 2 (defined as the number of abortions per 100 live births plus abortions) are based on pregnancy outcomes adjusted to the age at which conception occurred rather than the age at outcome. The adjustment is performed by reducing the woman's age at abortion by three months, and her age at birth by nine

Table 1. Number and percentage distribution of legal abortions, by selected characteristics, United States, 1982 and 1983

Characteristic	No.		% distribution	
	1982	1983	1982	1983
Total	**1,573,920**	**1,575,000**	**100.0**	**100.0**
Age				
<15	14,590	16,350	0.9	1.0
15–19	418,740	411,330	26.6	26.1
15–17	(168,410)	(166,440)	(10.7)	(10.6)
18–19	(250,330)	(244,890)	(15.9)	(15.5)
20–24	551,680	548,130	35.0	34.8
25–29	326,380	328,280	20.7	20.8
30–34	168,020	171,560	10.7	10.9
35–39	73,250	78,090	4.7	5.0
≥40	21,260	21,260	1.4	1.4
Race				
White	1,095,260	1,084,360	69.6	68.8
Nonwhite	478,660	490,640	30.4	31.2
Marital status				
Married	300,260	294,670	19.1	18.7
Unmarried*	1,273,660	1,280,330	80.9	81.3
No. of live births				
0	902,780	890,000	57.3	56.5
1	321,000	329,460	20.4	20.9
2	222,760	227,600	14.1	14.4
3	81,720	82,890	5.2	5.3
≥4	45,660	45,050	3.0	2.9
No. of prior induced abortions				
0	994,470	964,170	63.2	61.2
1	397,890	406,030	25.3	25.8
2	122,480	138,350	7.8	8.8
≥3	59,080	66,450	3.7	4.2
Weeks LMP				
≤8	805,590	792,050	51.2	50.3
9–10	419,520	424,240	26.7	26.9
11–12	205,390	210,100	13.0	13.3
13–15	75,500	83,080	4.8	5.3
16–20	53,800	53,260	3.4	3.4
≥21	14,120	12,270	0.9	0.8
Method				
Instrumental evacuation†	1,518,950	1,524,720	96.5	96.8
Medical induction‡	53,900	49,370	3.4	3.1
Hysterotomy/hysterectomy	1,070	910	0.07	0.06

*In this and subsequent tables, refers to the never-married, separated, divorced or widowed.

†Suction and sharp curettage; includes dilatation and evacuation at 13 weeks' gestation and later.

‡Intrauterine instillation of saline, prostaglandin, urea and, in some cases, combination procedures.

Sources: **Number of abortions**—for 1982, AGI abortion provider survey; for 1983, estimated from the 1982 and preliminary 1984 numbers. **Distribution by characteristic**—based on CDC, "Abortion Statistics, U.S., 1982–1983," prerelease and supplemental prerelease to state agencies, Atlanta, 1986. Data have been adjusted to assure comparability between years. In addition, the distribution by gestation and method have been computed by apportioning to clinics and physicians' offices one-half of the difference between the number of abortions estimated by the AGI and the number reported to the CDC; these abortions are assumed to have been performed at 12 or fewer weeks LMP by instrumental evacuation.

*For a discussion of the reasons for using physicians' estimates, see reference 1.

months.* In addition, births are lagged six months so that the calendar period of conception will be the same for births and abortions. The ratios may be interpreted as the percentage of pregnancies, excluding miscarriages and stillbirths, that end in abortion.

Overall, 30 percent of pregnancies were terminated by abortion in 1983 (the proportion is 26 percent when pregnancies estimated to have resulted in miscarriages and stillbirths are included in the denominator). The highest ratios—equaling 40 percent or more—were found among unmarried women (63 percent), women 40 and older (51 percent), teenagers (41–46 percent) and nonwhites (40 percent). The figure for nonwhites was almost 50 percent higher than that for whites, but this difference was smaller than the racial differential in abortion rates because nonwhite women had a higher birthrate as well as a higher abortion rate. The lowest ratio was seen among married women, who terminated only nine percent of their pregnancies. The abortion ratio stayed essentially the same between 1981 and 1983 among all women and among the demographic subgroups.

Table 3 illustrates the differences in abortion utilization by white and nonwhite women in 1983 according to their age and marital status. The abortion rate of nonwhite women was higher than that of whites at every age, but the differential was especially great among women younger than 15: Nonwhites in that category were more than five times as likely as whites to have an abortion. The abortion ratio was higher among nonwhites in all age-groups but one—the under-20 category. Here the ratio for nonwhites was lower, because in addition to having more abortions than whites, nonwhites also had many more births.

Nonwhite women usually use abortion to space their children or to terminate childbearing, whereas white women usually use it to postpone the onset of childbearing. Among all women obtaining abortions in 13 states in 1983, 61 percent of nonwhites had previously had a live birth, compared with 37 percent of whites. Among teenagers, the corresponding proportions were 23 percent and 10 percent.[5] (Data not shown.)

Among married women, as Table 3 shows, the rate of abortion use was nearly four times as high for nonwhites as for whites, but among the unmarried, the nonwhite rate was only about two-thirds higher than the white rate. In contrast, the proportion of pregnancies terminated by married nonwhites was nearly three times as high as it was for married whites, but in the case of unmarried women, nonwhites terminated a smaller proportion of pregnancies than did whites.

Table 4 (page 8) presents 1983 abortion numbers, rates and ratios examined simultaneously by the woman's age, marital status and race. Of all teenagers who had abortions, 96 percent were unmarried. In all, 289,790 white unmarried teenagers and 120,850 nonwhite unmarried teenagers obtained abortions. Of the women under age 15 who had abortions, most were nonwhite—8,900, compared with 7,450 white women.

The abortion rates of both married and unmarried women show the same pattern—a steady decline with increasing age—except in one respect: Unmarried teenagers have a lower rate than do unmarried women in the 20–29 age-groups, because many such adolescents are not sexually active. However,

Table 2. Rate of abortions per 1,000 women aged 15–44, and ratio of abortions per 100 abortions plus live births,* by age, race and marital status, 1981–1983

Characteristic	Rate			Ratio		
	1981	1982	1983	1981	1982	1983
Total	**29.3**	**28.8**	**28.5**	**30.1**	**30.0**	**30.4**
Age						
<20	44.8†	44.4†	45.2†	41.3	41.2	42.3
<15	8.6‡	8.3‡	9.1‡	43.7	42.9	46.0
15–19	43.3	42.9	43.5	41.2	41.2	42.2
15–17	(30.1)	(30.1)	(30.8)	(42.2)	(42.0)	(43.2)
18–19	(61.8)	(60.0)	(60.4)	(40.3)	(40.5)	(41.4)
20–24	51.1	51.2	51.1	30.4	30.6	31.4
25–29	31.4	31.5	31.1	22.0	22.3	22.5
30–34	17.7	17.7	17.8	23.9	23.2	23.0
35–39	9.5	9.3	9.6	35.7	34.2	34.2
≥40	3.4§	3.3§	3.1§	51.3	51.4	51.4
Race						
White	24.3	23.8	23.3	27.4	27.1	27.4
Nonwhite	55.9	55.5	55.8	39.2	39.2	40.1
Marital status						
Married	10.5	10.5	10.3	9.2	9.5	9.3
Unmarried	50.1	48.6	48.1	64.5	63.4	63.2

*In this table and Tables 3–4, denominator is number of abortions plus live births six months later (to match times of conception for pregnancies ending in births and pregnancies ending in abortions), both adjusted to age of woman at time of conception.

†In this and subsequent tables, denominator is number of women aged 15–19.

‡In this and subsequent tables, denominator is number of 14-year-old females.

§In this and subsequent tables, denominator is number of women aged 40–44.

Note: Some of the ratios shown above for 1981 differ slightly from those previously published (in reference 1), because the current figures are based on corrected birth data.

Sources: **1981**—see reference 1. **1982–1983**—**number of abortions:** see Table 1. **Number of women:** U.S. Bureau of the Census, "Estimates of the Population of the United States, by Age, Sex and Race: 1980 to 1984," *Current Population Reports (CPR)*, Series P–25, No. 965, 1985; ——, "Marital Status and Living Arrangements: March 1982," *CPR*, Series P–20, No. 380, 1983; and ——, "Marital Status and Living Arrangements, March 1983," *CPR*, Series P–20, No. 389, 1984. **Number of births:** National Center for Health Statistics, "Advance Report of Final Natality Statistics," *Monthly Vital Statistics Report* for 1982, Vol. 33, No. 6, Supplement, 1984; for 1983, Vol. 34, No. 6, Supplement, 1985; and for 1984, Vol. 35, No. 4, Supplement, 1986.

Table 3. Abortion rate and abortion ratio, by race, according to age and marital status, 1983

Characteristic	Rate		Ratio	
	White	Nonwhite	White	Nonwhite
Age				
<20	39.1	73.2	42.7	41.3
<15	(5.1)	(27.6)	(u)	(u)
15–19	(38.2)	(67.9)	(u)	(u)
20–24	42.7	93.9	28.5	40.8
25–29	24.5	65.3	18.6	37.6
30–34	13.9	38.5	19.1	37.8
35–39	7.7	20.8	30.8	45.5
≥40	2.7	5.6	50.6	53.9
Marital status				
Married	8.1	29.0	7.7	19.6
Unmarried	42.2	69.0	70.3	52.9

Note: In this and subsequent tables, u = unavailable.

Sources: **Number of abortions**—CDC, 1986 (see sources for Table 1), adjusted by an iterative procedure to the age, race and marital status distributions shown in Table 1. **Numbers of women and births**—see sources for Table 2.

*In practice, a certain proportion of the abortions and births at each age are shifted to one year earlier. For a description of the procedure and computer program used to estimate age at conception from age at birth or abortion, see: C. Tietze, *Induced Abortion: A World Review, 1983*, fifth ed., The Population Council, New York, 1983, p. 105.

Table 4. Estimated number of abortions, abortion rate and abortion ratio, by age, according to marital status and race, 1983

Measure	Married			Unmarried		
	Total	White	Nonwhite	Total	White	Nonwhite
No.	**294,670**	**208,220**	**86,450**	**1,280,330**	**876,140**	**404,190**
<15	80	0	80	16,270	7,450	8,820
15–19	16,960	14,040	2,920	394,370	282,340	112,030
20–24	80,590	58,850	21,740	467,540	322,530	145,010
25–29	87,710	59,600	28,110	240,570	157,010	83,560
30–34	62,930	42,690	20,240	108,630	70,290	38,340
35–39	35,130	24,650	10,480	42,960	29,130	13,830
≥40	11,270	8,390	2,880	9,990	7,390	2,600
Rate	**10**	**8**	**29**	**48**	**42**	**69**
<20	33	30	63	46	40	73
<15	u	0	u	9	5	27
15–19	33	30	61	44	39	68
20–24	20	16	64	69	61	101
25–29	14	10	41	58	51	82
30–34	9	7	27	38	34	49
35–39	6	5	17	19	18	25
≥40	2	2	5	6	6	8
Ratio	**9**	**7**	**19**	**63**	**70**	**52**
<20	6	5	11	58	66	45
20–24	8	7	17	65	72	53
25–29	8	6	19	67	73	58
30–34	11	9	22	68	73	61
35–39	21	18	33	72	75	65
≥40	40	36	46	78	82	68

Sources: **Number of abortions**—based on data from 13 states (see reference 5), adjusted by an iterative procedure to the 1983 totals shown in Table 1. **Numbers of women and births**—see sources for Table 2.

Table 5. Abortion rate, birthrate and pregnancy rate per 1,000 women aged 15–19, by race, 1977–1983

Measure	1977	1978	1979	1980	1981	1982	1983
All races							
Abortion rate	37.5	39.7	42.4	42.9	43.3	42.9	43.5
Birthrate	52.8	51.5	52.3	53.3	52.7	52.6	51.7
Pregnancy rate, age at outcome*	104.6	105.4	109.4	111.2	110.8	110.3	109.9
Pregnancy rate, age at conception*,†	119.3	122.5	127.2	127.6	128.5	127.4	125.9
White							
Abortion rate	u	34.9	38.3	38.3	38.5	38.1	38.2
Birthrate	44.1	42.9	43.7	45.0	44.7	44.5	43.6
Pregnancy rate, age at outcome*	u	89.9	94.6	96.1	95.0	95.2	94.3
Nonwhite							
Abortion rate	u	64.7	63.1	66.0	66.1	65.5	67.9
Birthrate	99.5	96.0	96.5	94.7	91.3	90.7	89.3
Pregnancy rate, age at outcome*	u	186.3	185.2	186.3	182.3	180.9	181.9

*Includes estimated number of pregnancies ending in miscarriages and stillbirths.

†Based on births six months later than abortions, to match time of conception for births and abortions; ages reduced by nine months for births and three months for abortions.

Sources: **Number of abortions**—joint distributions by age and race from the CDC (for 1982–1983, see sources for Table 1; for earlier years, see CDC, *Abortion Surveillance 1981*, Atlanta, 1985, and earlier volumes), adjusted by an iterative procedure to the age and racial distributions estimated by the AGI (for 1982–1983, see Table 1; for earlier years, see reference 2, pp. 62 and 64). **Number of women**—for 1977–1980, U.S. Bureau of the Census, "Preliminary Estimates of the Population of the United States, by Age, Sex and Race: 1970 to 1981," *Current Population Reports (CPR)*, Series P–25, No. 917, 1982, Table 2; for 1981, ——, "Estimates of the Population of the United States, by Age, Sex and Race: 1980 to 1983," *CPR*, Series P–25, No. 949, 1984, Table 2; for 1982–1983, see sources for Table 2. **Number of births**—National Center for Health Statistics, "Advance Report of Final Natality Statistics," *Monthly Vital Statistics Report*: for 1977, Vol. 27, No. 11, 1979; for 1978, Vol. 29, No. 1, 1980; for 1979, Vol. 30, No. 6, Supplement (2), 1981; for 1980, Vol. 31, No. 8, Supplement, 1982; for 1981, Vol. 32, No. 9, Supplement, 1983; for 1982–1984, see sources for Table 2.

when only unmarried teenagers who are sexually active are considered, their abortion rate is higher than that of unmarried women in any other age-group (not shown). Married adolescents also have a higher abortion rate than do married older women.

Whereas the rate of abortion decreases with a woman's age, the proportion of pregnancies terminated by abortion almost uniformly increases with age across the subgroups. The highest abortion ratio is found among unmarried white women 40 and older, who resolve 82 percent of their pregnancies by abortion.

In Table 5, rates of abortions and births among teenagers are summed, along with an estimate for miscarriages and stillbirths,* to yield the overall adolescent pregnancy rate in each of the years between 1977 and 1983. (Because there is such widespread concern over levels of teenage pregnancy in the United States, we have limited the calculations to 15–19-year-olds.) The pregnancy rate is based on age at pregnancy outcome (birth or abortion), because it is the measure more commonly used, it is easy to calculate and it is understood intuitively. However, basing the pregnancy rate on age at conception—which is nine months younger than the age at birth and 2–3 months younger than the age at abortion—is more accurate. To indicate the difference in the results produced by the two approaches, we show both pregnancy rates for teenagers of all races.

After rising through the 1970s, the teenage pregnancy rate peaked around 1980–1981 and fell slightly in 1982 and 1983. Among whites, the trend has mirrored the overall pattern, but among nonwhites, the pregnancy rate declined between 1980 and 1982, and then rose slightly in 1983. The abortion rate among white teenagers has remained unchanged since 1979; that for nonwhites increased in 1983, after having held steady the previous few years. Unlike the birthrate of white adolescents, the nonwhite rate has fallen continually since the 1960s.

The relative differentials between the pregnancy, birth and abortion rates of nonwhite and white teenagers narrowed somewhat between 1978 and 1981. The nonwhite pregnancy rate was 107 percent higher than the white rate in 1978, but was 90 percent higher in 1981. Similarly, the racial gap in the birthrate declined from 124 percent to 104 percent, and that in the abortion rate, from 85 percent to 72 percent. Between 1981 and 1983, however, the trend was reversed.

*The estimate—equaling 10 percent of abortions plus 20 percent of births—is based on a model developed by the late Christopher Tietze and by John Bongaarts of The Population Council.

and the racial differentials widened slightly—to 93 percent (in the pregnancy rate), 105 percent (in the birthrate) and 78 percent (in the abortion rate).

Conclusion

Overall, patterns of abortion utilization in the United States have been relatively stable in recent years. The majority of abortion patients continue to be young (under age 25), unmarried and white. The highest abortion rates are still found among women aged 18–19 and 20–24, among unmarried women and among nonwhite women; these are the groups that are most in need of programs for the prevention of unplanned pregnancy.

The lack of change in both the abortion rate and the proportion of pregnancies ending in abortion between 1981 and 1983 suggests that American couples continue to have difficulty in preventing unplanned pregnancies. Therefore, unless policy changes are made or new contraceptive technologies are introduced, it appears unlikely that major progress will be made in improving Americans' control over their fertility or in bringing disadvantaged groups closer to the rest of society in their ability to prevent unplanned pregnancy.

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The Harassment of U.S. Abortion Providers

By Jacqueline Darroch Forrest and Stanley K. Henshaw

Summary

In 1985, 47 percent of abortion providers experienced antiabortion harassment. The approximately 1,250 facilities that were affected served 83 percent of all abortion patients. Nonhospital facilities performing 400 or more abortions a year were the most likely targets of antiabortion activity; 88 percent reported at least one type of harassment during the year. Picketing occurred at 80 percent of these facilities. Only six percent experienced picketing alone; the average facility was subjected to five different types of activity. Seventy-three percent of the facilities were the target of at least one illegal activity.

A number of problems that made abortions more difficult or costly to provide were significantly related to the occurrence of antiabortion activity: increased expenditures for security and for legal services, loss of fire and casualty insurance, new licensing requirements and problems hiring staff. However, harassment did not appear to have affected the average number of abortions performed at large nonhospital facilities or the fee charged.

Background

Each year more than three million women in the United States experience an unplanned pregnancy.[1] About half of these women—1.5 million—obtain an abortion;[2] undoubtedly, many more consider the option of abortion.

Women who explore the availability of abortion in their area may hear not only the information they need about services, but also potentially frightening stories of harassment of providers and their patients by antiabortion activists. Such stories probably add to the stress of obtaining an abortion. In addition, harassment directed against abortion facilities threatens the very availability of abortion services for women who need them.

Harassment of providers, staff and patients includes such activities as picketing outside clinics, tracing the identity of patients and vandalizing and destroying facilities.[3] Bombings and arson are the most frightening and violent forms harassment takes. The National Abortion Federation has documented the extent of such incidents over the past 10 years. It reports that 51 providers received bomb threats in 1986, five were subjected to attempts at arson or bombing and six facilities were damaged or destroyed by such attacks.[4] Other forms of harassment can also have harmful effects on providers and on women forced to obtain abortions in a hostile environment. This article attempts to summarize the degree to which those involved in providing and obtaining legal abortions have encountered hostile activities in recent years.

In the most recent of its periodic surveys of abortion providers in the United States, The Alan Guttmacher Institute included a series of questions about the kinds of antiabortion activities that may affect the provision of services. The survey was fielded in the late spring and the summer of 1986. Hospital administrators were asked about the levels of outside pressure to restrict or eliminate abortion services that they had encountered in 1984 and 1985. Nonhospital providers were asked about 12 specific antiabortion activities, as well as about any problems they had had with insurance, licensing requirements and the general operation of their facilities. They were also asked whether the cost or difficulty of providing abortion services had significantly increased.

A total of 722 hospitals and 927 nonhospital facilities answered the questions on harassment. (Facilities that did not respond to the survey initially were sent the questionnaire a second time.) The respondents represented 62 percent of the total number of hospitals that provided abortion services in 1985 and 63 percent of the nonhospital facilities.

A comparison of providers that responded

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to the initial mailing with those that answered upon follow-up revealed no difference in the proportions subjected to harassment. Nevertheless, it is possible that providers who did not answer the questions on antiabortion activities were less likely to have experienced harassment than were those who answered the questions. If so, our estimates of the extent of harassment are inflated. Since it is not clear what, if any, bias exists in patterns of response, we have excluded all nonrespondents from the analysis.

Antiabortion Harassment

Analysis of the responses indicates that the level of harassment in 1985 varied by type and size of provider; however, no group was immune from such activity. Among the hospital providers, 29 percent reported that they did not know if there had been any pressure from outside the hospital to restrict or eliminate their abortion services. (In some cases, questionnaires were filled out by records staff rather than by administrators.) Of hospitals with information on the question, 36 percent had been subjected to such pressure in 1985; 64 percent had not. Hospitals providing 400 or more abortions during 1985 were slightly more likely to report such pressure than were those in which fewer abortions were performed (41 percent compared with 35 percent). Seventy-six percent of the hospitals reporting any antiabortion pressure in 1985 said it was more intense than it had been in 1984.

The level of pressure against nonhospital facilities providing abortion services appears to be greater than that directed at hospitals, although comparison is difficult because the two groups were asked different questions. Sixty-one percent of nonhospital facilities responding to the harassment questions reported that they had experienced at least one type of antiabortion activity during 1985. The level of activity differed widely by the average number of abortions the provider performed. Among facilities reporting fewer than 400 abortions (overwhelmingly, private physicians performing abortions in their offices), 30 percent had experienced at least one form of harassment, most commonly picketing (reported by 19 percent). Between two and 12 percent of the small-scale providers reported each of the 11 other types of harassment listed in the questionnaire.

Large nonhospital facilities (those providing 400 or more abortions per year) are the major source of abortion services for U.S. women. Such facilities, which may be either freestanding clinics or physicians' offices, accounted for 74 percent of all abortions performed in 1982.[5] Because of the major role of large nonhospital facilities in providing abortions, the remaining analysis in this article focuses on the 501 respondents who fell into this category.

Table 1. Percentage of large nonhospital facilities (those providing 400 or more abortions) that experienced harassment in 1985; percentage of affected facilities reporting multiple episodes of harassment; and percentage of affected facilities reporting an increase over 1984; by type of activity

Type of activity	All facilities (N = 501)	≥5 times	≥20 times	Increase from 1984
Picketing	80	82	68	50
Literature distributed inside facility	48	42	22	59
Bomb threats	48	15	3	58
Physical contact with or blocking of patients by picketers	47	62	34	56
Mass scheduling of no-show appointments	46	73	48	46
Demonstrations loud enough to be heard in patient areas	42	60	38	65
Invasion of facility by demonstrators	29	14	4	60
Vandalism	28	12	5	53
Jamming of telephone lines	22	54	41	66
Death threats	19	18	4	65
Tracing of patients' license plates	16	41	21	63
Picketing of homes of staff members	16	27	8	73

Eighty-eight percent of the large nonhospital facilities reported that they had experienced at least one type of antiabortion harassment during 1985. As Table 1 shows, the most widespread type of activity was picketing, which occurred at four out of five facilities. No other single activity was reported by more than half the providers, but almost half (42–48 percent) reported such activities as distribution of antiabortion literature inside the facility, bomb threats, physical contact with or blocking of patients by picketers, numerous no-show appointments made to disrupt the scheduling of legitimate patients and demonstrations loud enough to be heard by patients inside the facility. Twenty-nine percent of facilities were invaded by demonstrators in 1985, and almost as many were vandalized. More than 20 percent of facilities had their telephone lines jammed. Antiabortion harassment was directed against the staff members of a number of facilities: Nineteen percent of the providers said their staff members had received death threats, and 16 percent reported that the homes of staff members had been picketed. Sixteen percent of the providers reported that patients had been harassed with phone calls or visits at home after antiabortion activists had traced their license plates to ascertain the women's identities.

Antiabortion harassment was seldom limited to one type of activity. Only six percent of all respondents were subjected only to picketing, while 82 percent experienced multiple forms of harassment. On average,

Table 2. Percentage of large nonhospital facilities that reported antiabortion harassment, and among those reporting harassment, average number of types of activity reported, by characteristic of facility, 1985

Characteristic	Percent	Number of types of activity
All facilities	**88**	**5.0**
Type		
Clinic	92	5.3
MD's office	68	3.4
Region		
Midwest	95	5.7
South	93	5.4
East	84	4.4
West	76	4.3
Percent of visits for abortions		
≥75	96	5.5
50–74	87	5.7
25–49	89	5.1
10–24	85	4.5
<10	68	3.1

providers who experienced any harassment reported that five different types of antiabortion activity had been directed at the facility, its staff and patients. Between 92 and 100 percent of providers who were subjected to an activity other than picketing were also picketed. More than half of the facilities experiencing any form of antiabortion harassment also reported bomb threats (55–86 percent, depending on the other type of harassment reported), loud demonstrations (52–84 percent), physical contact with or blocking of patients by picketers (39–83 percent), false appointments (54–83 percent) and distribution of antiabortion literature inside the facility (57–82 percent). In addition, invasion of the facility by demonstrators was reported by at least half (50–62 percent) of the facilities that also reported physical contact between picketers and patients, loud demonstrations, distribution of literature inside the facility, tracing of patients' license plates and picketing of the homes of staff members. Approximately 54 percent of facilities subjected to phone jamming and tracing of patients' license plates also reported vandalism.

Under federal law, six of the 12 antiabortion activities listed in Table 1 are illegal: bomb threats, death threats, invasions by demonstrators, picketing involving physical contact with or blocking of patients, jamming of telephone lines and vandalism. Seventy-three percent of all facilities have been the target of at least one of these illegal activities. Activities other than these six are illegal in some states, depending on the circumstances.

As Table 1 shows, most instances of antiabortion harassment are not single, isolated occurrences, but rather part of a pattern of continuing pressure. Among providers subjected to at least one of five antiabortion activities—picketing, physical contact with or blocking of patients by picketers, mass scheduling of no-show appointments, loud demonstrations and jamming of phone lines—the majority reported that the activity had occurred at least five times; and a large minority said it had occurred 20 times or more. Even the less common forms of harassment occurred five or more times in at least 12 percent of the facilities subjected to such activities.

Of the providers who reported some type of antiabortion harassment (except the scheduling of no-show appointments), at least half said that the activity had occurred more frequently in 1985 than in 1984. It is possible that respondents simply perceived an increase that they could not verify. However, because the proportions reporting an increase varied across the types of activity, it appears that providers were not responding merely to an overall impression (see Table 1, column 4). The forms of harassment experienced by fewer than 25 percent of the providers—phone jamming, death threats, tracing of patients' identities and picketing of staff homes—are among those most often described as having increased.

"The American public generally opposes the violence that has been directed against abortion providers. Yet . . . antiabortion harassment is widespread and frequent, takes many forms and increased in intensity between 1984 and 1985."

Frequent Targets

While antiabortion activity against large nonhospital facilities is widespread, certain characteristics may identify the providers most likely to be targets of harassment. On the basis of the number of different types of antiabortion activities reported by providers of more than 400 abortions in 1985, and the number of times those activities occurred, an index of harassment was developed. A multiple regression analysis using this index (not shown) found that the characteristics significantly associated with harassment were type of facility, region of the country and proportion of patient visits that involved abortion services. Characteristics that bore no significant relationship to the degree of harassment in 1985 were the number of abortions performed beyond 400, the change between 1984 and 1985 in the number of abortions performed, the maximum gestation at which abortions were performed and the amount charged for an abortion.

Table 2 summarizes the findings for those characteristics found to be statistically significant. While 88 percent of all large nonhospital facilities reported at least one type of antiabortion activity, 92 percent of clinics did so, compared with 68 percent of physicians' offices. Clinics that experienced any of the 12 types of antiabortion activity measured reported an average of 5.3 types, compared with an average of 3.4 types at office facilities. Offices were less likely to report each specific type of harassment, and were especially less likely to report bomb threats, vandalism and death threats. There was no difference, however, in the proportions of clinics and offices that reported an increase in harassment between 1984 and 1985 (not shown).

Almost all large-scale providers located in the Midwest and the South reported antiabortion harassment in 1985 (95 and 93 percent, respectively). Providers in those regions who experienced harassment reported an average of 5.4–5.7 types of antiabortion activity. Although harassment was very common in the East and the West, the extent of antiabortion activity there was significantly lower than in the Midwest and the South. Antiabortion activities were reported by 84 percent of providers in the East and 76 percent in the West. They reported, on average, 4.4 and 4.3 types of activity, respectively.

Reports of harassment were greatest among health care facilities that were primarily providers of abortion services. In the case of facilities to which the majority of patients came in order to obtain abortions, at least 87 percent experienced some form of antiabortion harassment in 1985. Facilities serving mostly abortion patients were also subject to more types of antiabortion activities than were other providers. However, the majority of facilities where most patients came for reasons other than abortion were also subjected to harassment. Sixty-eight percent of facili-

Table 3. Percentage of large nonhospital facilities that experienced service problems, according to antiabortion activity, by type of problem

Type of service problem	All facilities (N= 473)	No activity (N= 55)	Picketing only (N= 29)	Activity beyond picketing (N= 391)
Higher security costs (nonpersonnel)	44	12	7	52**
Higher legal costs	44	25	14	49**
Increased security personnel	32	6	7	37**
Malpractice insurance ended	31	18	32	32
New license requirements	26	5	21	29*
Difficulty hiring staff	25	9	7	28*
Fire and casualty insurance ended	21	4	14	24*
Difficulty obtaining hospital backup	10	10	3	11

*Significant relationship between service problem and antiabortion activity other than picketing at $p<0.01$.

**Significant relationship at $p<0.001$.

ties where fewer than 10 percent of patient visits were for abortions reported antiabortion activity, and they cited an average of 3.1 types of harassment.

Other Pressures

In addition to questions about specific antiabortion activities, the survey also asked large nonhospital providers about more general problems that may be linked to the provision of abortions. Table 3 (page 11) shows that 44 percent of providers reported that within the 12 months prior to the survey, they had been forced to increase expenditures for security (other than personnel), and 44 percent had incurred increased legal expenses. Thirty-two percent had had to employ more security personnel, and a similar proportion had been notified that their malpractice insurance was being canceled or would not be renewed. Twenty-six percent said they had been asked to meet new or newly interpreted licensing requirements, and 25 percent reported greater difficulty hiring staff. Twenty-one percent of the facilities had been notified that their fire and casualty insurance was being terminated. Ten percent of providers cited greater difficulty arranging for hospital backup.

Malpractice insurance termination and increased difficulty arranging for hospital backup were the only problems not significantly related to the occurrence of antiabortion harassment. Fifty-two percent of the providers that had experienced harassment other than picketing reported increased expenses for security other than personnel in the last 12 months, compared with only 12 percent of providers untouched by the types of antiabortion activity covered in the survey. Facilities that increased their expenditures for security and their security personnel were especially likely to have experienced physical contact with or blocking of patients by picketers, loud demonstrations, distribution of antiabortion literature inside the facility, vandalism, invasion by demonstrators and bomb threats (not shown).

Although 25 percent of providers who reported no antiabortion activity in 1985 said they had incurred increased legal costs, providers who had experienced harassment that went beyond picketing were twice as likely to report an increase in their legal expenses. The forms of harassment that facilities with increased legal expenses were most likely to have been subjected to were picketing that included physical contact with patients, loud demonstrations, distribution of antiabortion literature inside the facility and no-show appointments (not shown).

Providers were much more likely to have had problems with licensing requirements, hiring of staff and fire and casualty insurance if they had experienced antiabortion harassment. Those facilities that reported problems with licensing requirements were particularly most likely to have experienced harassment through bomb threats, mass scheduling of no-show appointments and physical contact between picketers and patients (not shown).

Providers who had found it harder to hire staff in the previous 12 months were more likely to report physical contact with or blocking of patients by picketers, loud demonstrations, bomb threats, no-show appointments and tracing of license plates (not shown). Those providers who were notified that their fire and casualty insurance would be terminated were especially likely to have experienced bomb threats and loud demonstrations in 1985 (not shown).

Malpractice insurance difficulties, although not significantly related to antiabortion activity in this analysis, were nonetheless considered by providers to be one of their biggest problems. Abortion providers were asked an open-ended question about whether any factors in the previous year had greatly increased their costs or had made it more difficult for them to provide abortion services. About half (53 percent) said yes, and the most common factor was malpractice insurance (cited by 36 percent of those who found services more costly or difficult to provide). Although clinics were more likely than office facilities to have been subjected to all types of antiabortion activities, more physicians' offices than clinics cited malpractice insurance problems (50 percent compared with 34 percent). This finding provides further evidence that malpractice insurance problems are probably unrelated to antiabortion activity.

Other frequently cited factors, listed by 13–18 percent of facilities reporting increased difficulties providing abortion services, were increased expenditures for security, fire and casualty insurance problems, picketing and increased legal expenses. Only three percent of office providers said security costs were making abortion services more difficult or costly to provide, compared with 21 percent of clinic providers.

Discussion

The data from this analysis demonstrate that the providers of abortion services are subjected to special pressures, even if such services are a very small part of their overall practice. Antiabortion activists have publicly proclaimed that their goal is to stop the provision of abortion services.[6] As it is, women's access to abortion services rests on the existence of a relatively small number of facilities willing and able to provide this specific type of health care. For example, in 1982, only 26 percent of the 5,400 short-term general non-Catholic hospitals in the United States performed any abortions.[7] Of the 21,000 office-based obstetrician-gynecologists in the United States in 1982, fewer than half (42 percent) provided abortion services.[8] As a result of the lack of facilities, many women

have had difficulty obtaining abortions. In 1982, 28 percent of all women aged 15–44 lived in counties where there was no abortion provider,[9] and in 1981, 101,000 women went outside their states of residence to obtain abortions.[10]

In a future article presenting other data from the AGI abortion provider survey, we will investigate whether there have been any sharp changes in the number and types of facilities providing abortion services in the United States. This analysis indicates, however, that antiabortion activity directed against a clinic or physician is unrelated to any change between 1984 and 1985 in the average number of abortions provided by large nonhospital facilities still offering abortion services in 1985. Thus, we conclude that the harassment of abortion providers has not succeeded in reducing the number of abortions performed by the facilities analyzed.

Our analysis has shown, however, that many types of harassment employed by antiabortion activists result in higher costs to providers for insurance, increased security and legal representation. Yet preliminary data suggest that the average charge in real dollars for a first-trimester nonhospital abortion declined between 1983 and 1986 (that is, after adjusting for changes in the cost of living).[11] It remains to be seen whether the problem of obtaining insurance and the other external pressures on abortion facilities will force providers to increase their charges in the future.

The data presented in this article demonstrate the extent to which antiabortion activities—in the form of bomb and death threats and picketing of homes—affect the staff of abortion facilities. In no other U.S. setting are health care workers likely to be threatened for providing services that are legal.

We estimate that if the respondents in our survey are representative of all abortion providers of similar types and sizes, then 47 percent of all U.S. providers (approximately 1,250) were subjected to antiabortion pressure in 1985. Since harassment affects almost all of the large nonhospital facilities, which serve most of the country's abortion patients, the proportion of such patients who obtained abortions in 1985 from providers that were subjected to antiabortion pressure was even greater—83 percent.

Harassment is usually not continual, and many of the women who went to clinics, hospitals or doctors' offices may not have personally witnessed or been subjected to antiabortion activities. However, many were probably aware that such activities might occur during their visit, and it is appropriate to question whether that awareness made obtaining an abortion more difficult for them than was necessary.

For women who do encounter direct harassment, obtaining an abortion can be a frightening experience. Patients and their companions who enter a facility that is being picketed run the risk of verbal assault, possible physical contact and even harassment at home afterward. The effects of such harassment on women who are already undergoing a stressful experience can only be adverse. Since most of the health care providers we surveyed also offer services other than abortion, patients seeking other types of care may encounter harassment as well.

The American public generally opposes the violence that has been directed against abortion providers.[12] Yet our study shows that antiabortion harassment in the United States is widespread and frequent, takes many forms and increased in intensity between 1984 and 1985.

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Public Funding of Contraceptive, Sterilization And Abortion Services, 1985

By Rachel Benson Gold and Jennifer Macias

Summary

In FY 1985, the federal and state governments spent $398 million to provide contraceptive services and supplies. The two leading sources of funding were the Medicaid program and Title X of the Public Health Service Act. The former accounted for $137 million, or 34 percent of all public expenditures; and the latter program accounted for $133 million, also 34 percent. Two block-grant programs—Social Services and Maternal and Child Health—provided $40 million and $23 million, respectively; together, they were responsible for 16 percent of public support for contraceptive services. State governments, which spent $64 million of their own revenues, accounted for another 16 percent of funding.

The federal and state governments together spent $64 million to subsidize sterilizations in FY 1985. The federal government provided 94 percent of the funding—84 percent through the Medicaid program. In addition, the states and the federal government spent $66 million to subsidize 188,000 abortions; in this case, however, the federal government contributed less than one percent of the funds used.

These data come from a survey of state agencies, and should be viewed as approximations rather than as precise figures.

Sources of Funds

Federal funds for family planning services come primarily from four sources: Title X of the Public Health Service Act, the Maternal and Child Health (MCH) and Social Services block-grant programs (Titles V and XX of the Social Security Act, respectively), and Medicaid (Title XIX of the Social Security Act). Title X, the only federal program designed specifically to provide family planning services, is administered by the Department of Health and Human Services; the DHHS directly awards Title X grants to state health departments, hospitals, family planning councils and other public and private nonprofit providers of family planning services. The two block-grant programs, in contrast, are administered by the states, which thus control the types of services that are provided and the distribution of federal funds to support those services. The federal MCH funds generally go to state health agencies, and the Social Services funds, to state welfare agencies. The state agencies either provide services directly or arrange for them to be provided. States may use their block-grant allotments to provide family planning services, but are not required to do so.

Before MCH block-grant funds are given to the states, 10–15 percent of the total allocation is set aside for special programs of national or regional significance, such as genetic services and hemophilia programs. Grants under the set-aside portion are awarded directly by the DHHS. The remaining 85–90 percent of MCH block-grant funds are then allocated to the states. Every four federal MCH dollars received by a state must be matched with three dollars in state funds. Unlike the MCH block grant, the Social Services block grant includes neither a set-aside component nor a requirement that states match federal funds with their own dollars.

The fourth major source of federal funds is Medicaid, a joint federal-state program designed to provide necessary health services to the very poor—generally, members of families who are eligible for Aid to Families with Dependent Children. Since Medicaid, unlike the other sources of funding for family planning services, is an entitlement program, spending under the program is controlled not by a direct congressional appropriation but rather by the number of people eligible to receive Medicaid benefits. Except for Arizona, all states and the District of Columbia participate in the Medicaid program. Since 1982, Arizona has had a demonstration program similar to Medicaid, but in FY 1985 it did not include family planning services.

The federal government reimburses state Medicaid expenditures at rates established by the DHHS. Each state is assigned a specific federal reimbursement rate applicable to most of the services provided through the program; family planning services, however, are reimbursed at the special matching rate of nine federal dollars for every state dollar spent. Despite the existence of this special rate, the DHHS has never issued a formal, nationally applicable definition of family planning. As a result, the services for which federal reimbursement is claimed at the special rate can differ from state to state.

In addition to federal funds, most states use at least some of their own revenues to provide family planning services. These state funds come from a variety of sources, including specific appropriations made by state legislatures for family planning services, general health or welfare agency funds that are allocated to family planning, and the states' general assistance programs. Some states provide family planning services through their Medicaid programs to people who do not meet the eligibility criteria for federal Medicaid reimbursement. Services provided through these state-only portions of Medicaid are funded entirely with state dollars.

Funding Data

For more than a decade, The Alan Guttmacher Institute (AGI) has conducted periodic surveys of state agencies to determine their expenditures for family planning services through the main federal programs, as well as their use of state revenues for such services. Until now, the most recent figures available have been those for FY 1983.[1] In April 1986, the AGI sent questionnaires to every state health and welfare agency and state Medicaid program, requesting data for federal FY 1985 (October 1, 1984, through September 30, 1985). With a few exceptions, every state and the District of Columbia re-

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Table 1. Reported public expenditures for contraceptive services and supplies (in 000s of dollars), by funding source, according to state, FY 1985

State	Total	Federal sources					State sources
		Total	Medicaid*	Title X†	Social Services block grant*	MCH block grant*	
U.S. total	**$397,599**	**$333,738**	**$137,082**	**$133,494**	**$40,051**	**$23,111**	**$63,861**
Alabama	6,314	6,214	2,513	3,351	u	350	100
Alaska	353	353	nr	353	nr	nr	nr
Arizona	3,770	3,770	0‡	2,940	300	530	0
Arkansas	2,215	2,125	0	1,848	0	277	90
California	50,267	27,455	14,927	12,528	0	0	22,812
Colorado	3,023	2,121	707	1,414	0	0	902
Connecticut	3,570	3,570	1,124	1,259	1,157	30	0
Delaware	1,424	1,227	668	526	0	33	197§
D.C.	1,170	1,170	505	558	0	107	0
Florida	17,271	5,546	891	4,070	0	585	11,725
Georgia	10,648	9,899	5,627**	4,272	0	0	749
Hawaii	1,853	1,290	408	830	u	52	563
Idaho	1,167	1,167	100	640	0	427	0
Illinois	16,477	15,779	8,580	3,901	2,208	7,090	698
Indiana	8,020	8,020	1,923	2,413	2,600	1,084	0
Iowa	4,622	4,476	2,642	1,679	155	0	146
Kansas	2,016	1,991	697	1,294	u	0	25
Kentucky	5,441	5,441	1,632	2,418	0	1,391	0
Louisiana	9,956	6,858	3,334	2,664	0	860	3,098
Maine	3,947	2,693	1,416	927	350	0	1,254
Maryland	8,337	7,743	4,654	2,442	0	647	594
Massachusetts	8,098	7,771	2,748	3,520	1,243	260	327
Michigan	14,174	13,509	8,404	4,302	0	803	665§
Minnesota	5,214	4,350	2,287††	1,665	0	398	864§
Mississippi	3,906	3,788	nr	2,959	829	0	118
Missouri	5,788	5,788	2,272	3,099	0	417	0
Montana	1,196	1,196	nr	966	nr	230‡‡	u
Nebraska	1,436	1,436	356	983	0	97	0
Nevada	1,079	1,079	242	837	0	0	0
New Hampshire	1,310	1,232	182	608	427	15	78
New Jersey	11,292	10,848	3,578	4,489	1,915	866	444
New Mexico	2,740	2,140	801	1,076	93§§	170	600
New York	38,419	32,731	19,252	8,189	3,100§§	2,190	5,688
North Carolina	7,667	7,474	557	4,213	2,394*†	310	193
North Dakota	702	702	179	404	0	119	0
Ohio	22,712	22,712	16,365	5,808	575	164	u
Oklahoma	6,944	3,536	888	2,125	0	523	3,408
Oregon	3,275	3,071	777	1,757	0	537	204
Pennsylvania	19,128	18,736	6,013	7,127	4,780	816	392
Rhode Island	757	727	405	311	11	0	30§
South Carolina	5,792	3,104	99	2,990	0	15	2,688
South Dakota	579	579	122	457	0	0	0
Tennessee	9,685	8,970	1,982**	3,780	2,387	821	715
Texas	32,699	31,677	3,737	8,932	13,568§§	5,440	1,022§
Utah	707	707	u	573	0	134	0
Vermont	1,089	1,089	373	448	248§§	0	u
Virginia	6,263	6,263	1,922	2,838	1,003§§	500	0
Washington	7,817	5,532	1,998	3,534	0	0	2,285
West Virginia	2,703	2,523	473	1,149	678	223	180
Wisconsin	12,125	11,125	8,722**	1,773	30	600	1,000
Wyoming	462	455	nr	455	0	0	7

*Includes federal and state funds. †Includes federal funds only.

‡Arizona's demonstration Medicaid program does not cover family planning services.

§Includes funds for sterilization services. **Includes funds for sterilization services.

††Includes funds from the state's refugee program.

‡‡Includes $203,000 from the Preventive Health block grant. §§Includes funds for sterilization services.

*†Includes funds from the Low Income Energy Assistance program.

Note: In this and following tables, u = unavailable (state reported expenditures but could not specify amount); nr = no response (state did not respond to survey).

sponded to the survey (Alaska did not respond to the health agency survey; Alaska, Arizona and Montana did not respond to the welfare agency survey; and Alaska, Mississippi, Montana and Wyoming did not respond to the Medicaid survey). Data on funding under the Title X program were obtained from the DHHS and include all Title X grants for family planning services made in a state.[2]

Although the data generated by both the current and the previous AGI surveys of state agencies represent the most complete account of public funding that is available, the data nonetheless have serious limitations. The first problem is that a complete separation of federal and state expenditures is not always possible. Both Medicaid and the MCH block grant require partial state matching of federal dollars. In addition, some states use their own funds to supplement their federal Social Services block-grant allotments, even though there is no matching requirement. In the data reported here, as in the data for previous years, state (matching) supplements to the federal Medicaid, MCH and Social Services programs have been combined with federal funds, while state expenditures not made specifically to match federal funds have been counted separately. Consequently, the federal contribution to public funding has been overestimated, and the state share has been underestimated.

A second problem is that to permit comparison with data from previous years, the 1985 data focus on medical family planning services, which include outpatient and inpatient hospital services, physician and clinic services, and prescription drugs. However, expenditures for nonmedical services (such as outreach, staffing, administration, education, training and research) have become increasingly difficult to isolate from other outlays, and thus it has not been possible to exclude them in all cases.

In recent years, it has also become harder to separate expenditures for contraceptive services (excluding sterilization) from expenditures for other medical family planning services, such as infertility and prenatal genetic diagnosis and treatment and screening for sexually transmitted diseases. While affecting all funding sources, this problem is most acute in the case of Medicaid. For example, 36 states and the District of Columbia reported covering prenatal genetic services through their Medicaid programs in FY 1985 (up from 24 states and the District in FY 1979), nearly all of the 36 included their expenditures for such care in the amount they reported for contraceptive services.

It is also not always possible to distinguish

expenditures for sterilization from those for reversible methods (the two sets of expenditures are reported separately in this article). Most but not all of the state Medicaid agencies could isolate the amounts paid for sterilization; but only about one-third of the state health agencies could identify the Title X funds so used. We also have no data on the use of Title X monies for sterilization by grantees other than state health agencies.

All of these problems have been compounded by the decrease in accountability that affects programs funded through block grants to the states (as compared with categorical programs such as Title X), and by the budget cuts experienced by federal agencies in the last few years. Consequently, the AGI data presented below should be viewed as providing an approximation of general trends rather than a precise accounting.

Contraceptive Services and Supplies

As Table 1 shows, all 50 states and the District of Columbia reported spending $397.6 million for contraceptive services (excluding sterilization wherever possible) in FY 1985. Federal funds constituted 84 percent of the total. Although Medicaid surpassed Title X somewhat in dollars spent ($137.1 million vs. $133.5 million), each program accounted for about 34 percent of all public expenditures. The Social Services block grant provided $40.1 million, or 10 percent of total public funds spent, and the MCH block grant provided $23.1 million, or six percent.

Forty-three states and the District of Columbia said they funded contraceptive services and supplies through the Medicaid program in FY 1985. Of the states that responded to the AGI survey, only Arkansas reported no Medicaid expenditures (Utah was unable to specify dollar amounts, and Arizona's demonstration Medicaid program does not cover family planning services). California, New York and Ohio together reported spending $50.5 million, or 37 percent of total Medicaid expenditures for contraceptive services. All states that reported expenditures said they had claimed federal reimbursement at the 90 percent matching rate for family planning.

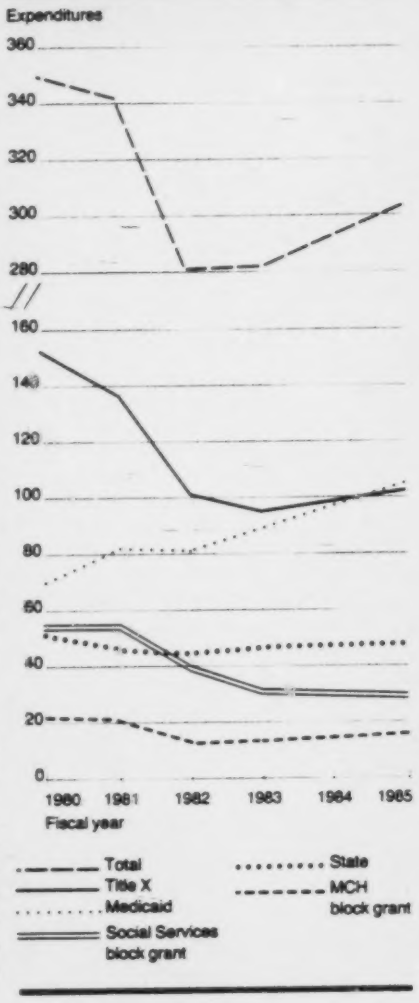
All the states and the District of Columbia received some Title X funds in FY 1985. Together, five states—California, New York, Ohio, Pennsylvania and Texas—accounted for 32 percent of all Title X funds spent during the fiscal year.

Twenty-two states reported funding contraceptive services through their Social Services block grants. (Three additional states reported such expenditures, but were not able to provide data.) As in previous surveys, Texas reported the largest outlay under the Social Services block grant, amounting to 34 percent of the sum spent nationwide. Thirty-six states and the District of Columbia reported spending some of their MCH block-grant funds for contraceptive services; the largest such expenditure occurred, again, in Texas (24 percent of the total).

Thirty-four states used $63.9 million of their own revenues (three other states made expenditures, but could not provide figures). Ten states each spent at least $1 million of their own funds. Slightly more than half of all state funding came from just two states, California and Florida; indeed, California alone was responsible for 36 percent of total state outlays. Thirty states spent $59 million through their state health agencies; six states spent some $3 million through the state-only portions of their Medicaid programs; six spent nearly $2 million through their general assistance programs; and one state, Iowa, used other welfare agency funds.

Thus, in FY 1985 wide variations existed among the states in the pattern and extent of public funding for contraceptive services. Title X was the chief source of funding in 32 states and the District of Columbia, and Medicaid was the chief source in 13 states. While two states, Texas and Indiana, reported greater expenditures through the Social Services block grant than through any other single program, in no state was the MCH block grant the primary funding source. Three states—California, Florida and Oklahoma—supported services mainly with their own revenues. Total reported expenditures exceeded $15 million each in California, Florida, Illinois, New York, Ohio, Pennsylvania and Texas; these seven states were responsible for half of all reported public expenditures nationwide. The largest single expenditure was made by California (13 percent of the national total). Only six states reported spending less than $1 million each for contraceptive services and supplies.

Figure 1. Reported public expenditures for contraceptive services and supplies, by funding source, FY 1980–FY 1985 (in 000s of constant [1980] dollars)



Funding Trends

Figure 1 illustrates the changes in expenditures that have occurred since FY 1980; to adjust for the effects of inflation, funding levels are expressed in constant (1980) dollars. Between FY 1981 and FY 1982, under the first budget authored by the Reagan administration, total federal and state funding for contraceptive services and supplies declined by 18 percent (from $341.9 million to $280.3 million). The reduction stemmed from cuts of 27–29 percent in the Title X, MCH and Social Services programs, appropriations for which are directly controlled by Congress. State funding and spending under Medicaid, neither of which was directly affected by the administration's budget cuts, also declined, but by a slight proportion. Since then, the only program that has shown clear and sustained growth has been Medicaid. In FY 1985, consequently, total public spending for contraceptive services remained below the levels reached in FY 1980 and FY 1981.

Together, Title X and the two block-grant programs have been contributing a diminishing share of total national expenditures for such services—49 percent in FY 1985, compared with 65 percent in FY 1980. The role played by Medicaid and state spending, on the other hand, has become more important. Although the number of people eligible to receive health care through Medicaid has remained virtually unchanged since FY 1981,[4] expenditures under the program for contraceptive services have risen by 29 percent (in constant dollars). One reason is that

Table 2. Reported public expenditures for sterilizations (in 000s of dollars), by funding source, according to state, FY 1985

State	Total	Federal sources					State sources
		Total	Medicaid*	Social Services block grant*	Title X†	MCH block grant*	
U.S. total	**$63,800**	**$59,978**	**$53,330**	**$3,428**	**$2,518**	**$702**	**$3,822**
Alabama	2,739	2,739	2,726	u	13	0	0
Alaska	nr	nr	nr	nr	nr	nr	nr
Arizona	u	u	0‡	nr	0	0	nr
Arkansas	814	814	771	0	0	43	0
California	6,108	4,291	4,291	0	0	0	1,817
Colorado	656	555	555	0	0	0	101
Connecticut	1,393	1,393	1,393	0	0	0	0
Delaware	310	310	310	0	0	0	0
D.C.	82	82	82	0	0	0	0
Florida	1,126	1,126	191	0	935	0	0
Georgia	86	u	u	0	0	0	86
Hawaii	826	704	704	u	0	0	122
Idaho	513	513	438	0	75	0	0
Illinois	4,201	4,063	3,954	0	109	0	138
Indiana	2,158	2,158	2,158	0	0	0	0
Iowa	1,414	1,414	1,404	0	10	0	0
Kansas	439	409	409	u	0	0	30
Kentucky	2,964	2,964	2,332	0	632	0	0
Louisiana	1,307	1,307	1,307	0	0	0	0
Maine	273	209	209	0	0	0	64
Maryland	1,299	1,299	1,299	0	0	0	0
Massachusetts	735	735	735	0	0	0	0
Michigan	3,577	3,577	3,577	0	0	0	u
Minnesota	648	622	622	0	0	0	26
Mississippi	796	439	nr	0	130	309§	357
Missouri	786	786	786	0	0	0	u
Montana	6	6	nr	nr	6	0	u
Nebraska	185	185	185	0	0	0	0
Nevada	73	73	73	0	0	0	0
New Hampshire	15	15	15	0	0	0	0
New Jersey	1,878	1,843	1,843	0	0	0	35
New Mexico	331	331	316	u	15	0	0
New York	5,052	4,686	4,686	u	0	0	366
North Carolina	2,662	2,662	1,780	865	17	0	0
North Dakota	127	127	119	0	8	0	0
Ohio	2,391	2,391	2,391	0	0	0	u
Oklahoma	517	517	517	0	0	0	0
Oregon	358	358	358	0	0	0	0
Pennsylvania	3,979	3,466	3,466	0	0	0	513
Rhode Island	158	158	158	0	0	0	0
South Carolina	1,394	1,394	1,007	0	191	196	0
South Dakota	103	103	87	0	16	0	0
Tennessee	417	378	u	0	224	154	39
Texas	6,894	6,894	4,331	2,563	u	u	u
Utah	u	u	u	0	0	0	0
Vermont	67	67	67	u	0	0	u
Virginia	617	617	617	u	0	0	0
Washington	1,023	895	895	0	0	0	128
West Virginia	303	303	166	0	137	0	0
Wisconsin	u	u	u	0	0	0	u
Wyoming	u	u	nr	0	0	0	u

*Includes federal and state funds. †Includes federal funds only.

‡Arizona's demonstration Medicaid program does not cover family planning services.

§Includes $45,000 from the Appalachian Regional Commission.

of all the sources of funds for family planning, Medicaid is the most directly responsive to inflation and to changes in the cost of providing medical care. As the cost of providing services has grown, Medicaid expenditures have grown. A second reason is that increasingly, noncontraceptive services are being offered as part of comprehensive medical family planning services; we are sometimes unable to distinguish in the Medicaid data between the cost of such services and the cost of contraceptive services. As for state expenditures, many states have made special appropriations for family planning services, and a few have launched special comprehensive initiatives for dealing with teenage pregnancy that include provision of contraceptive services as a crucial, but perhaps small, component. (Again, as contraceptive services are integrated into these comprehensive programs, specific expenditures for contraceptive care become harder to isolate from total program expenditures.)

Sterilization Services

One-third of U.S. women who use a method of contraception rely on either female or male sterilization, making sterilization the leading contraceptive method.[5] As Table 2 shows, 45 states and the District of Columbia said they spent $63.8 million in public funds for sterilization services in FY 1985. The three states reporting the largest expenditures—California, New York and Texas, each of which spent at least $5 million—accounted for 28 percent of the total amount spent.

Ninety-four percent of public funds came from federal sources. Medicaid was by far the major source of public funding, accounting for 84 percent of all public expenditures for sterilization in the fiscal year. Forty-one states and the District of Columbia spent $53.3 million through the program; four other states reported sterilization expenditures, but were unable to separate them from total contraceptive expenditures under Medicaid. However, just six states accounted for 46 percent of Medicaid sterilization expenditures nationwide, and three of them—California, New York and Texas—accounted for 25 percent.

The other federal programs combined provided 10 percent of total public funding. North Carolina and Texas together reported spending $3.4 million through the Social Services block grant; seven additional states spent unspecified amounts. Four states used $700,000 in MCH block-grant funds; a fifth state reported MCH outlays, but was unable to supply the figures. Title X funds, used by 15 states, amounted to $2.5 million.

Fourteen states spent $3.8 million of their own revenues for sterilization. Eight other

Table 3. Reported public expenditures for abortions (in 000s of dollars) and number of publicly funded abortions, by funding source, according to state and state policy, FY 1985

State and policy	Expenditures			No. of abortions		
	Total	Federal*	State	Total	Federal*	State
U.S. total	**$66,171**	**$312**	**$65,859**	**187,997**	**484**	**187,513**
NONRESTRICTIVE	65,907	59	65,848	187,547	86	187,461
Voluntary	**27,137**	**54**	**27,083**	**85,978**	**88**	**85,890**
Alaska	nr	nr	nr	nr	nr	nr
Colorado	241	19	222	947	74	873
D.C.	1,092	0	1,092	3,464	0	3,464
Hawaii	928	0	928	1,800	0	1,800
Maryland	1,780	0	1,780	3,484	0	3,484
Michigan	6,351	0	6,351	20,620	0	20,620
New York†	13,400	0	13,400	43,000	0	43,000
North Carolina	1,375	35	1,340	6,576	12	6,564
Oregon	324	0	324	1,602	0	1,602
Washington‡	1,574	0	1,574	4,025	0	4,025
West Virginia	72	0	72	458	0	458
Court order	**38,770**	**5**	**38,765**	**101,571**	**0**	**101,571**
California	31,224	0	31,224	84,000	0	84,000
Connecticut	489	5	484	u	u	u
Massachusetts	1,338	0	1,338	7,497	0	7,497
New Jersey	5,688	0	5,688	9,891	0	9,891
Vermont	31	0	31	183	0	183
RESTRICTIVE	264	253	11	450	398	52
Life only	**243**	**243**	**0**	**378**	**378**	**0**
Alabama	2	2	0	10	10	0
Arizona	0	0§	0	0	0§	0
Arkansas	1	1	0	2	2	0
Delaware	2	2	0	3	3	0
Florida	**	**	0	1	1	0
Georgia	0	0	0	0	0	0
Idaho	7	7	0	6	6	0
Illinois	1	1	0	6	6	0
Indiana	**	**	0	1	1	0
Kansas	0	0	0	0	0	0
Kentucky	0	0	0	0	0	0
Louisiana	0	0	0	0	0	0
Maine	9	9	0	7	7	0
Mississippi	nr	nr	nr	nr	nr	nr
Missouri	0	0	0	0	0	0
Montana	nr	nr	nr	nr	nr	nr
Nebraska	**	**	0	1	1	0
Nevada	**	**	0	1	1	0
New Hampshire	0	0	0	0	0	0
New Mexico	0	0	0	0	0	0
North Dakota	0	0	0	0	0	0
Ohio	196	196	0	306	306	0
Oklahoma	0	0	0	0	0	0
Rhode Island	0	0	0	0	0	0
South Carolina	5	5	0	3	3	0
South Dakota	0	0	0	0	0	0
Tennessee	8	8	0	20	20	0
Texas	12	12	0	11	11	0
Utah	0	0	0	0	0	0
Other restrictions	**21**	**10**	**11**	**72**	**20**	**52**
Iowa	5	2	3	20	11	9
Minnesota	2	2	0	4	4	0
Pennsylvania	0	0	0	0	0	0
Virginia	14	6	8	48	5	43
Wisconsin	0	0	0	0	0	0
Wyoming	nr	nr	nr	nr	nr	nr

*Under Medicaid; expenditures include both federal and state funds for procedures eligible for federal reimbursement.

†Data are for FY 1983.

‡Expenditures represent funds spent by the state health and Medicaid agencies; number of abortions includes only those funded through the state Medicaid agency.

§Arizona's demonstration Medicaid program does not cover abortions.

**Less than $500.

states also used their own funds, but could not report the amounts involved. California alone was responsible for 48 percent of all state sterilization expenditures. State funds came from several sources: $1 million from the state segments of Medicaid programs, to provide services for people not eligible for federal reimbursement under the program (seven states);* $2.5 million from state health agencies (six states); and almost $300,000 from state welfare agencies (four states).

Abortion Services

The implementation of the Hyde Amendment in 1977 virtually eliminated any federal role in providing subsidized abortion services for poor women in the United States.† For all of FY 1985, federal funds could be used for abortions only in the minuscule number of cases in which the life of the woman would be endangered if the pregnancy were carried to term. As Table 3 shows, 20 states reported claiming $312,000 in federal funds to provide 484 abortions in FY 1985. Ohio alone accounted for 63 percent of the number of federally subsidized procedures, and for 63 percent of the federal funds spent.

A number of states use their own monies to provide publicly funded abortion services for poor women. Sixteen states and the District of Columbia reported spending $65.9 million to fund 187,513 abortions in FY 1985. Almost all of those procedures were performed in the 15 states (and District of Columbia) that followed a policy of paying for all or most medically necessary abortions for indigent women.‡ Most of these jurisdictions used the

*Such persons either are ineligible for federal programs or are eligible but do not meet the criteria for federal funding of their sterilizations. Since 1979, DHHS regulations have placed strict limits on sterilizations that are provided under Medicaid. The regulations require a detailed and complex informed consent procedure, mandate a 30-day waiting period between the time when the woman gives her consent and the date the sterilization is performed, and prohibit the sterilization of anyone who is under age 21 or mentally incompetent. (See: *Federal Register*, 43: 52146, 1978.)

†Hyde Amendments have been attached to the annual appropriations bills for the Department of Labor and the DHHS every year since 1977. Although the original sponsor, Rep. Henry J. Hyde (R.-Ill.), has not always sponsored the amendment since 1977, the amendment has nonetheless always borne his name.

‡In one of those states, Colorado, a ballot referendum approved by the voters on Nov. 6, 1984, changed the state's funding policy from the one shown in the table. As of June 4, 1985, the state pays for abortions only in cases of life endangerment, fetal defect or a "psychiatric condition which represents a serious and substantial threat to the life of the pregnant woman." Similar referenda were defeated in Washington in 1984 and in Arkansas, Massachusetts, Oregon and Rhode Island in 1986. As a result, the funding policies of all states (except Colorado) and the District of Columbia remain unchanged from those in effect in 1985.

definition of medically necessary abortion that was set forth in the Supreme Court's 1973 abortion decisions—that is, "one that is required in light of all factors—physical, emotional, psychological, familial and the woman's age—relevant to the well-being of the patient." Nine of the 15 states plus the District of Columbia paid for abortions voluntarily; the other five (California, Connecticut, Massachusetts, New Jersey and Vermont) did so under court order. California and New York reported the largest numbers of state-funded abortions: Together they accounted for two-thirds of all such procedures.

Twenty-nine states had a policy of funding abortions only in cases of life endangerment, but none of them paid for any abortions during the 1985 fiscal year. Six other states operated under policies just slightly less restrictive: In Minnesota, Pennsylvania, Wisconsin and Wyoming, the grounds for state funding were life endangerment, rape and incest (Wyoming's policy was broadened from "life only" midway through the fiscal year); in Iowa and Virginia, the grounds were life endangerment, rape and diagnosis of a severe genetic defect in the fetus. These last two states funded 52 abortions in FY 1985; the other four states paid for no abortions.

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Public Benefits and Costs Of Government Funding for Abortion

By Aida Torres, Patricia Donovan, Nancy Dittes and Jacqueline Darroch Forrest

Summary

In state referenda to end public funding of abortions for poor women, one of the most successful tactics of abortion foes has been to charge that abortion funding increases the burden on taxpayers. A state-by-state analysis by The Alan Guttmacher Institute (AGI) shows that the opposite is the case. For every tax dollar spent to pay for abortions for poor women, about four dollars is saved in public medical and welfare expenditures. The savings are in public expenditures that otherwise would have to be incurred because of the babies that poor women would have borne. On the basis of earlier research, it was assumed that 20 percent of Medicaid-eligible women who could not obtain abortions would give birth. Public costs examined in the AGI analysis include Medicaid expenditures for prenatal care, delivery and postnatal care for the mother, and for newborn care, neonatal intensive care and pediatric care for the child for the first two years of life; as well as expenditures for Aid to Families with Dependent Children (AFDC), food stamps and the Special Supplemental Food Program for Women, Infants and Children (WIC) during those first two years.

The benefit-to-cost ratio varies from about 9:1 in Massachusetts to 2:1 in Hawaii and Pennsylvania. The net savings for the nation as a whole over a two-year period if abortions were publicly funded in every state would total at least $339.6 million.

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"Public funding of abortions . . . saves money at the same time that it helps to ensure that poor women have control over their childbearing, so that they will not be forced to bear . . . children at a time when they . . . are not prepared to do so."

Introduction

On November 4, referenda to end public funding of abortions for indigent women are expected to be held in four or five states.* Getting such referenda on the ballot is becoming an increasingly popular tactic with right-to-life groups in states that continue to pay for abortions for Medicaid-eligible women.†

The strategy received a considerable boost in 1984, when Colorado voters narrowly passed an amendment to the state constitution that prohibits the use of state funds to pay for abortions except when continuation of the pregnancy would endanger the woman's life. (Colorado had paid for abortions for Medicaid-eligible women since 1969.) The sponsors of the referendum, who called themselves Citizens for Responsible Government and were largely antiabortion activists, characterized the proposed funding cutoff as a cost-saving measure. Their message was simple and persuasive: "Why should your tax dollars pay the bill for those who choose to have an abortion? . . . This is an unfair burden imposed on Coloradans, who each year see their taxes grow higher and higher."[1] The clear implication was that abortion funding caused that annual tax increase. Some political analysts believe that the cost argument convinced as many as 20 percent of the voters to support the amendment.[2]

A 1974 study by health department officials in New York City compared the costs of paying for abortions for indigent women there with those of paying for maternity care and public assistance for indigent women and their babies if publicly funded abortions were not available. The authors estimated that government expenditures for such first-year health and welfare costs would be 7–10 times higher than what the government spent in 1973 for abortions for Medicaid recipients.[3] The investigators assumed that all women who were denied Medicaid funding for abortions would carry their pregnancies to term. In a subsequent benefit-cost study for New York State, it was assumed that only 25 percent of pregnancies terminated by Medicaid-financed abortions would be carried to term if Medicaid funding were not available.[4] The researchers found that under this assumption (which was based on studies of states that stopped paying for abortions for poor women), the benefit-cost ratio was two dollars saved in public health and welfare expenditures for every Medicaid dollar spent for abortion services. (However, the benefits were estimated as 8:1 if all pregnancies were carried to term.)

Other estimates of the increased costs to states entailed by a cutoff in publicly subsidized abortion services have been made in the course of campaigns for various antifunding referenda. These estimates indicated that state expenditures could be 7–9 times higher if maternity care and delivery were subsidized for indigent women unable to get an abortion, and 15–20 times higher to cover welfare costs in the first year or two of the baby's life.[5] These cost estimates were undoubtedly helpful in individual campaigns in informing voters of the high cost of eliminat-

*Arkansas, Massachusetts, Oregon, Washington and, possibly, Rhode Island.

†All of the states in which an antifunding referendum is expected this year, except Arkansas and Rhode Island, are currently paying for abortions.

ing abortion funding. However, because the assumptions used to reach these figures are unstated or not consistent across states, it is not appropriate to apply these estimates to other states or to the country as a whole.

This article presents the results of an AGI study that sought to develop consistent data for each state on the public costs of funding abortions for indigent women as compared with public expenditures for maternity care, infant care, AFDC and food stamps for women who carry their pregnancies to term because publicly funded abortions are not available in their state.

Background

Most publicly funded abortions that are currently provided to Medicaid-eligible women are paid for with state funds.* Before the Supreme Court legalized abortion throughout the country in 1973, only a handful of state Medicaid programs covered abortion, unless the procedure was necessary to save the woman's life.[6] These policies reflected the fact that although some states had liberalized their abortion laws, a majority prohibited abortion except when the woman's life was threatened. By mid-1974, however, three-fourths of the states had policies calling on them to pay for abortions performed by a physician for a Medicaid-eligible woman.[7]

There were no restrictions on federal Medicaid payments for abortion until 1976, when Congress passed the so-called Hyde Amendment, limiting reimbursements to abortions needed to save the woman's life. Enforcement, however, was delayed until a federal court's restraining order was lifted on August 4, 1977. Since then, except for the first seven months of 1980 (when federal Medicaid funding was resumed, pending a Supreme Court ruling on the constitutionality of the Hyde Amendment), federal payments for abortion have been severely restricted. The conditions under which the goverment will pay, however, have changed slightly over the years. In 1978 and 1979, new versions of the Hyde Amendment† permitted funding when a pregnancy resulted from rape or incest, if the crime was promptly reported to law enforcement officials, or if two physicians confirmed that the woman would suffer severe and long-lasting physical health damage if her pregnancy continued. In 1980, the criterion of physical health damage was dropped. Since June 5, 1981, abortions have been reimbursable under Medicaid only if the woman's life would be endangered by carrying the pregnancy to term.

Even before passage of the Hyde Amendment, it was generally believed that if public funding for abortion were eliminated, indigent women would be left with only two options: to carry an unplanned pregnancy to term or to obtain a dangerous, illegal abortion. For example, researchers at the Centers for Disease Control (CDC) estimated in 1977 that the funding cutoff would result in 5–90 excess deaths each year.[8] Eighteen months after the Hyde Amendment went into effect, however, the CDC found only three deaths associated with the funding restrictions.[9]

Although the Hyde Amendment restrictions had an immediate and substantial impact on the ability of poor women to obtain abortions, predictions of a negative impact proved to be exaggerated because they overlooked the actual funding situation before the amendment was passed, assumed that all states would follow the restrictive federal policy and incorrectly estimated what women's behavior would be.

In 1977, before enforcement of the Hyde Amendment began, six states‡ did not pay for any abortions for Medicaid recipients, and another 13 states§ paid for fewer than one-quarter of the abortions estimated as needed by such women. A total of 133,000 Medicaid-eligible women—about one-third of the 427,000 who were estimated to be in need of government-subsidized abortion services—were unable to obtain a publicly funded abortion in 1977, because the services were not available or accessible to them, or because the states had policies prohibiting such payments.[10]

In 1978, the first year the Hyde Amendment was in effect, the estimated unmet need for subsidized abortions increased by 76 percent to about 234,000 women.[11] Most of the additional 100,000 women who were unable to obtain a publicly funded abortion paid for a legal procedure with their own funds, although often at the expense of providing basic necessities for their families.[12] However, an estimated 20 percent of those women who would have obtained abortions under more liberal funding policies went on to give birth.[13]

That the unmet need rose no higher than it did reflected the fact that a number of states, including some with large Medicaid-eligible populations, continued to pay for abortions for indigent women with their own funds. In 1978, for example, 16 states and the District of Columbia paid for almost 192,000 abortions for poor women, while the federal government and the remaining states paid for only 2,100 abortions.[14] Although the number of states that pay for abortions has declined slightly since 1978, 14 states** and the District of Columbia currently subsidize abortion services for Medicaid-eligible women, at least in part. In this article, local, state and federal government expenditures for abortion services are estimated and compared with public expenditures that could be saved because of births averted as a result of government funding for abortions.

Abortions for Medicaid-Eligible Women

As shown in column 1 of Table 1 (page 114), there are an estimated five million Medicaid-eligible women aged 15–44 in the United States. About 1.4 million of them live in the nine northeastern states, and 1.5 million live in the 12 North Central states. About 1.2 million reside in 16 states in the South and the District of Columbia. In the remaining 13 western states, there are an estimated 960,000 Medicaid-eligible women.[15] Regional estimates from the March 1985 Current Population Survey (CPS) were distributed among states according to FY 1984 proportions of Medicaid recipients who were dependent children under age 21, who were adults in families with dependent children and who were classified as medically needy.[16] Overall, the estimated number of Medicaid-eligible women aged 15–44 represented 25 percent of the nearly 20 million Medicaid recipients in 1984.††

The most recent information about the numbers of patients and levels of expenditures for abortion services is taken from a 1984 AGI survey of state health and welfare agencies and state Medicaid programs.[17] It showed that 15 states‡‡ and the District of

*Ed. note: For a discussion of Medicaid eligibility, see the article on page 103 of this issue.

†The amendment retains the name of its first sponsor, Rep. Henry Hyde (R.-Ill.), although the subsequent versions have been sponsored by other members of Congress.

‡Arizona (which had no Medicaid program), Indiana, Louisiana, Mississippi, North Dakota and South Dakota.

§Alabama, Arkansas, Idaho, Kentucky, Maine, Massachusetts, New Hampshire, North Carolina, Oklahoma, South Carolina, Tennessee, Utah and West Virginia.

**Alaska, California, Connecticut, Hawaii, Maryland, Massachusetts, Michigan, New Jersey, New York, North Carolina, Oregon, Vermont, Washington and West Virginia.

††Arizona has no Medicaid program. The numbers of Medicaid-eligible women shown in Table 1 were estimated on the basis of the number of public assistance recipients enrolled in prepaid plans reported by the state and on the national proportion of women aged 15–44 who were Medicaid-eligible (25 percent).

‡‡Alaska, California, Colorado, Connecticut, Hawaii, Massachusetts, Maryland, Michigan, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Washington and West Virginia.

Columbia had policies that permitted state funding for substantial numbers of Medicaid abortions. These states accounted for virtually all public expenditures for abortion and for all publicly subsidized patients served during FY 1983. In these 15 states, more than 99 percent of publicly funded abortions were paid for with state funds.

Two estimates were prepared of the likely number of subsidized abortions that Medicaid-eligible women would obtain in each state under hypothetical nonrestrictive policies. These are shown as a range in column 2 of Table 1. Ten states* and the District of Columbia have relatively nonrestrictive policies; for these, reported publicly funded abortions are used. For all other states the lower estimates are based on the assumption that the abortion rate for Medicaid-eligible women in 1977, prior to enforcement of the Hyde Amendment, prevailed in 1984, adjusted upward or downward by the same percentage as resident-abortion rates have changed. The basic assumption underlying the higher estimates is that if funding policies were more liberal, states that provided minimal or no funding for abortions in FY 1983 would serve Medicaid-eligible women to the same extent that the 10 states with liberal abortion funding policies did in FY 1983.†

On the basis of these assumptions, the total number of abortions that would be paid for by Medicaid is estimated to be 303,000–394,000, as may be seen in column 2 of Table 1. Estimates are lower under the first assumption than under the second, except in the 10 states with nonrestrictive policies and the District of Columbia and in Georgia and Nevada.‡ The estimated average public expenditure per abortion in the states that in FY 1983 paid for abortions for Medicaid-eligible women is shown in column 4. These range from $159 in West Virginia to $756 in Alaska. For the states that had restrictive abortion funding policies in that year, the mean public expenditure ($292) per abortion by states with relatively liberal funding policies was used.§

Medical Care and Social Welfare Costs

To calculate the saving resulting from averted births, public expenditures are estimated for medical services for full-term pregnancy, delivery and infant care, and for social welfare benefits in the first two years of an infant's life. Social welfare costs are limited to payments for AFDC and nutrition programs. Excluded because of the difficulty in obtaining information about these expenditures, are administrative costs, maternal and child health expenditures not covered by Medicaid, and expenditures for foster and institutional care of children and for infant day care. Also excluded are expenditures for public housing. Estimates of the average first two-year costs per birth for each state are shown in Table 2 (page 115).

• *Maternity care costs.* In November 1985, the AGI surveyed state Medicaid programs for data about expenditures and numbers of patients who were receiving maternity and infant care. Data about maternity care have been analyzed in another report.[18] The estimated average expenditures derived in that analysis are shown in column 1 of Table 2. These figures include physician fees for prenatal, delivery and postpartum services, and hospital charges for the mother and the healthy newborn (excluding specialized infant services, such as neonatal intensive care).

The weighted average government expenditure for maternity care is $2,200 per birth. The expenditure is lowest in Louisiana and highest in Tennessee ($1,310 and $3,520, respectively).

• *Infant care costs.* The AGI survey of state agencies asked respondents to supply data from which it would be possible to estimate the public expenditure per birth for medical services in the infant's first two years of life. Few states, however, were able to provide all of the data necessary for this calculation. Although 26 states furnished some data on infant care expenditures, only eight of them provided total costs that could be used to estimate costs for the first two years of the infant's life.** In order to determine these expenditures in the remaining states, reimbursement rates furnished by the states were used, in conjunction with service utilization data from other sources, as described below.††

For the 42 states where reimbursement rates were used, it was first necessary to estimate the amount of medical care—physician visits and hospital days—provided to the average child. For this estimate, the authors used national data about patterns of children's use of pediatric care and hospital care from the 1980–1981 National Ambulatory Medical Care Survey, the 1983 National Hospital Discharge Survey and the 1980 National Natality Survey, all conducted by the National Center for Health Statistics. State-specific reimbursement rates were applied to infant care utilization data to estimate the expenditures per birth. In cases where the reimbursement rate was not furnished, the mean rate for all reporting states was used.

On the basis of data obtained from the 1980–1981 National Ambulatory Medical

*Alaska, California, Colorado, Hawaii, Massachusetts, Michigan, New Jersey, New York, North Carolina and Washington.

†Only estimates under the first assumption are shown for Georgia and Nevada, which have restrictive policies. These states had relatively high Medicaid-abortion rates in 1977, and their resident-abortion rates have increased since that time by 10 and 25 percent, respectively. Estimates of abortions for Georgia are similar whichever assumption is used, whereas the numbers for Nevada are higher under the first than under the second assumption.

‡Actually, 15 states and the District of Columbia had liberal abortion funding policies in FY 1983. (Ten had liberal policies and five were providing funding under court order.) However, five of them (Connecticut, Maryland, Oregon, Pennsylvania and West Virginia) had much lower abortion rates in 1984 than in 1977 and, thus, appear to pay for only some of the abortions obtained by Medicaid-eligible women. These five were, therefore, included among the 40 states for which estimates were made using the two assumptions. For six states (Arizona, Indiana, Louisiana, Mississippi and the Dakotas), data on Medicaid-funded abortions prior to enforcement of the Hyde Amendment were unavailable. To provide the missing data for these states, it was assumed that had they paid for abortions obtained by indigent women, their Medicaid-abortion rates would have been similar to the 1977 rates in neighboring states that funded abortions. To reflect changes in resident-abortion rates between 1977 and 1984, abortion rates by residence for 1977 through 1981 were updated, on the basis of available 1982–1984 abortion rates by occurrence. (Source: AGI, *Abortion Services in the United States, Each State and Metropolitan Area, 1981–1982*, New York, 1985; and S. K. Henshaw, "Trends in Abortion, 1982–1984," *Family Planning Perspectives*, 18:34, 1986, and unpublished data from responses of 31 states to the AGI survey of health departments upon which that article was based.)

§Alaska and Hawaii reported extremely high abortion expenditures—$756 and $664 per patient, respectively. Since these states have the highest cost of living in the country and are, therefore, not representative of the country as a whole, their per-patient abortion expenditures were excluded in calculating the average of $292.

**Nine states could provide only aggregate data for the first three or more years of life. Another seven states reported estimates of expenditures in the first two years, but showed far more patients receiving infant care than could be reasonably expected, given the reported number of Medicaid-funded births. (The number of recipients reported for the first two years of life was more than 2.5 times the number of births, or was reported in thousands of units of services. It was not clear from the data whether children aged two were counted among the patients, or what infant care services were included.) The remaining two states submitted partial information.

††A small number of infants, of course, would die before completing their first two years. No adjustments were made for infant mortality during the two-year period, because it would be impossible to determine just when in the time period the deaths would occur and, therefore, the amount of infant care that would and would not be needed. About 1.1 percent of infants die before the age of one, and this percentage decreases each year. (See: National Center for Health Statistics, DHHS, "Annual Summary of Births, Marriages, Divorces and Deaths, United States, 1984," *Monthly Vital Statistics Report*, Vol. 33, No. 13, 1985, p. 7.) This proportion representing about 1,200 births averted, would not affect the benefit-cost ratios shown in Table 3.

Table 1. Estimated number of Medicaid-eligible women aged 15–44, number of Medicaid-funded abortions, abortion rate and public expenditure per abortion, by state, circa 1985

Region and state	No. of eligible women (1)	No. of Medicaid-funded abortions (2)	Medicaid abortions per 1,000 women (3)	Public expenditure per abortion* (4)
U.S. total	**5,040,900**	**302,760–384,130**	**60.1–78.2**	**$315**
Northeast	**1,439,100**	**78,680–95,680**	**53.3–66.5**	**338**
Conn.†	83,400	1,850–4,570	29.1–72.0	191
Maine	33,700	700–2,430	20.9–72.0	292
Mass.†	133,800	8,550	63.9	165
N.H.†	14,500	270–1,040	18.4–72.0	292
N.J.†	150,300	8,890	59.1	427
N.Y.†	565,400	43,000	64.6	312
Pa.†	336,300	11,950–24,210	35.5–72.0	524
R.I.	27,400	920–1,970	33.6–72.0	292
Vt.	14,300	560–1,030	39.1–72.0	292
North Central	**1,450,200**	**70,790–96,380**	**48.8–66.5**	**296**
Ill.	290,900	19,390–20,940	66.7–72.0	292
Ind.	61,400	1,590–4,420	25.9–72.0	292
Iowa	50,000	1,070–3,600	21.4–72.0	292
Kans.	4,400	2,930–3,170	66.7–72.0	292
Mich.†	383,400	19,570	51.0	308
Minn.	107,600	3,640–7,750	33.8–72.0	292
Mo.	69,700	1,860–5,020	26.7–72.0	292
Nebr.	22,800	1,110–1,640	48.8–72.0	292
N. Dak.	10,900	480–780	44.4–72.0	292
Ohio	217,700	10,440–19,560	38.4–72.0	292
S. Dak.	5,100	190–370	37.6–72.0	292
Wisc.	132,800	8,510–9,560	64.1–72.0	292
South	**1,188,800**	**45,280–87,010**	**38.1–73.2**	**285**
Ala.	54,900	1,250–3,950	22.7–72.0	292
Ark.	35,700	900–2,570	25.2–72.0	292
Del.	11,200	780–800	69.7–72.0	292
D.C.†	28,400	4,390	154.8	265‡
Fla.	107,200	6,620–7,720	61.8–72.0	292
Ga.	87,100	6,270	72.0	292
Ky.	168,800	2,020–12,150	12.0–72.0	292
La.	27,600	610–1,990	22.2–72.0	292
Md.†	93,900	2,980–6,760	31.8–72.0	446
Miss.	43,900	750–3,160	17.1–72.0	292
N.C.†	98,500	6,160	62.5	205
Okla.	59,000	1,020–4,250	17.4–72.0	292
S.C.	68,900	1,470–4,960	21.3–72.0	292
Tenn.	53,500	620–3,850	11.6–72.0	292
Tex.	122,400	4,100–8,810	33.5–72.0	292
Va.	73,500	4,860–5,290	63.4–72.0	292
W. Va.	54,300	670–3,910	12.4–72.0	159
West	**962,800**	**110,010–115,060**	**114.3–119.5**	**324**
Alaska†	3,500	310	88.3	756
Ariz.	35,500	990–2,560	28.0–72.0	292
Calif.†	740,000	100,000	135.1	319
Colo.†	28,900	1,740	60.0	256
Hawaii†	22,300	1,790	80.6	664
Idaho	5,300	100–390	17.8–72.0	292
Mont.	11,800	400–850	33.5–72.0	292
Nev.	4,200	370	86.6	292
N.M.	12,000	350–870	29.1–72.0	292
Oreg.†	24,200	530–1,740	21.9–72.0	192
Utah	15,400	230–1,110	15.3–72.0	292
Wash.	55,500	3,050	55.0	316
Wyo.	4,100	160–290	38.6–72.0	292

*Average public expenditure per abortion for the United States and the four regions, based on the lower estimate of Medicaid-funded abortions.

†State-funded abortions for Medicaid-eligible women in 1983. ‡Average for FY 1982–1983.

Care Survey for all U.S. infants,[19] it was estimated that each infant would make an average of seven pediatric visits in the first two years of life—4.4 in the first year and 2.6 in the second year. These figures are somewhat lower than the number of well-baby visits recommended by the American Academy of Pediatrics—six visits in the first year and three in the second year.[20] The cost to the state and federal governments of providing for seven pediatric visits per infant was derived from state-specific rates for one pediatric visit. When the state's reimbursement rate was not available, the mean for 32 reporting states was employed.

According to findings from the 1983 National Hospital Discharge Survey,[21] 25.6 percent of infants are hospitalized at some time during their first year for reasons other than newborn care. Those who are hospitalized spend an average of 6.6 days in the hospital; 8.1 percent of infants between the ages of one and four are hospitalized each year for an average of 3.7 days each. Assuming that one-year-olds stay for close to the average for 1–4-year-olds, it was estimated that the state would provide for an average of two days of hospital care in the infant's first two years of life, 1.7 days of it in the first year. State and federal government expenditures for hospital care for an average of two days per newborn were estimated by applying the state's average per diem rate for illness or injury, or the mean rate for 19 reporting states. It should be emphasized that this estimate does not include hospital charges for newborn care.

Thirteen states provided information about levels of expenditures for and the number of newborns who obtain neonatal intensive care. In these states, 6.1 percent of infants born to women who were Medicaid recipients required intensive care, a proportion similar to that for all infants estimated by the Office of Technology Assessment.[22] Data from the 1980 National Natality Survey indicate that newborn infants who are sick for seven or more days stay in the hospital an average of 18.7 days.[23] On the basis of these data, the state could expect to have to pay for 1.1 days of neonatal intensive care per newborn. The state's per diem rate for neonatal intensive care or, for states not providing data, the mean for 21 states with available rates was used. Expenditures per birth for pediatric care, hospital care and neonatal intensive care are shown as expenditures for infant care in column 2 of Table 2. The estimated average government expenditure for the first two years of an infant's life is $1,770 for the nation as a whole. Expenditures range from $730 in West Virginia to $3,110 in Alaska.

AFDC Benefits

With the birth of a child, AFDC payments for the United States would be expected to increase by an average of $1,890 exclusive of administrative costs (column 3). This figure reflects the probability that the addition of a new person to an indigent family will result in a new addition to the AFDC rolls and add to the costs of welfare for new and existing cases.

Included among the five million Medicaid-eligible women of reproductive age in 1985 were women in families that receive cash assistance (AFDC or other welfare assistance) and women who are eligible for cash or Medicaid assistance but are not currently receiving cash payments.[24] From the 1985 CPS and state Medicaid figures, it is estimated that 3.9 million Medicaid-eligible women, or 78 percent of all such women in the United States, were from families receiving cash assistance. In the Northeast, 79 percent of Medicaid-eligible women were welfare recipients. The proportion is 86 percent in the North Central states, 76 percent in the South, and 69 percent in the West.

In order to estimate the increase in public assistance expenditures resulting from a birth to a Medicaid-eligible woman, it was assumed that for women who are welfare recipients, additional payments would be required for the new baby. For the remaining Medicaid-eligible women, the additional payments would be for new cases. (The number of new cases is underestimated by an unknown proportion of young women on welfare who might move out of the parental home and create a new AFDC family.)

Public expenditures for AFDC continue each month the family or child needs public assistance. In an analysis of duration of welfare use from 1975 AFDC case records, June O'Neill and her colleagues found that 50 percent of welfare recipients remained on the rolls for at least 12 months, and 31 percent were recipients for at least 24 months.[25] In a similar analysis, based on data for female heads of households with children from the Panel Survey of Income Dynamics (PSID), Mary Jo Bane and David Ellwood found that 71 percent stayed on welfare for at least one year, and that 52 percent remained on the rolls for two years or more.[26] The proportions from the study of AFDC cases were believed by the present authors to better reflect the length of time AFDC recipients stay on the rolls. Many who leave the program return, however. Bane and Ellwood found that 23 percent of women who leave the welfare rolls return within a year.[27] By using the proportion who remain on welfare from the 1975 AFDC case records and the proportion who return from the PSID study, and by assum-

Table 2. Average medical and social welfare expenditures in the first two years of an infant's life per Medicaid-funded birth, circa 1985

Region and state	Maternity care* (1)	Infant care† (2)	AFDC (All cases) (3)	Food stamps (4)	WIC (5)	Expenditure/birth (6)
U.S. total‡	**$2,200**	**$1,770**	**$1,890**	**$310**	**$580**	**$6,750**
Northeast‡	**2,260**	**1,450**	**2,050**	**300**	**570**	**6,620**
Conn.	2,240	1,890 (1)	2,300	280	610	7,320
Maine	1,920	1,430 (2)	2,000	270	550	6,170
Mass.	2,770	1,700 (3)	2,010	310	560	7,350
N.H.	1,420	1,180 (4)	1,710	330	580	5,220
N.J.	2,970	1,480 (2)	1,910	300	570	7,230
N.Y.	2,090	1,410 (1)	2,230	290	620	6,650
Penn.	2,020	1,320 (5)	1,790	300	440	5,870
R.I.	1,940	1,480 (6)	1,860	320	600	6,190
Vt.	1,970	1,450 (1)	2,370	290	540	6,630
North Central‡	**2,420**	**1,380**	**$1,510**	**300**	**540**	**6,130**
Ill.	1,860	1,390 (1)	1,290	320	550	5,410
Ind.	2,120	1,480 (6)	1,180	320	520	5,620
Iowa	1,490	1,030 (1)	1,410	320	530	4,780
Kan.	2,100	1,110 (1)	1,390	320	600	5,530
Mich.	2,940	1,490 (5)	1,810	280	550	7,070
Minn.	2,320	1,480 (6)	2,060	270	520	6,650
Mo.	2,270	900 (7)	1,100	340	620	5,220
Nebr.	2,010	1,440 (1)	1,490	300	570	5,810
N. Dak.	1,910	1,520 (2)	1,550	300	610	5,880
Ohio	2,930	1,540 (2)	1,260	320	490	6,550
S. Dak.	1,910	1,480 (6)	1,150	350	580	5,470
Wisc.	2,630	1,020 (8)	2,150	280	490	6,550
South‡	**2,210**	**1,800**	**1,130**	**380**	**590**	**5,870**
Ala.	1,610	1,340 (1)	660	380	550	4,530
Ark.	1,890	1,850 (1)	940	370	700	5,760
Del.	2,020	1,470 (2)	1,560	320	590	5,960
D.C.	2,190	1,540 (9)	1,710	320	590	6,360
Fla.	2,750	1,520 (10)	1,240	350	590	6,450
Ga.	2,430	1,530 (11)	1,110	370	580	6,010
Ky.	1,710	1,130 (1)	1,030	370	620	4,850
La.	1,310	1,550 (7)	1,040	350	620	4,870
Md.	2,680	2,260 (12)	1,720	320	520	7,490
Miss.	1,480	1,480 (6)	620	390	440	4,400
N.C.	3,080	1,290 (8)	1,090	380	570	6,420
Okla.	1,650	1,160 (1)	1,520	330	650	5,300
S.C.	1,630	1,150 (13)	1,010	360	600	4,750
Tenn.	3,520	1,580 (13)	810	370	640	6,920
Tex.	1,550	2,100 (13)	900	380	580	5,510
Va.	1,440	1,840 (1)	1,520	330	570	5,700
W. Va.	1,430	730 (1)	1,320	340	570	4,400
West‡	**1,920**	**2,590**	**2,940**	**290**	**650**	**8,380**
Alaska	3,270	3,110 (4)	3,810	310	840	11,340
Ariz.	2,140	1,480 (6)	1,340	360	670	5,980
Calif.	1,840	2,890 (13)	3,160	280	650	8,820
Colo.	1,700	1,270 (1)	2,040	320	580	5,910
Hawaii	1,950	1,480 (6)	2,630	310	860	7,230
Idaho	1,340	2,110 (13)	1,650	350	640	6,090
Mont.	2,190	1,480 (2)	2,020	330	580	6,590
Nev.	2,370	2,160 (14)	1,640	350	590	7,120
N.M.	2,850	1,420 (11)	1,490	350	650	6,760
Oreg.	2,200	1,500 (13)	2,300	330	600	6,910
Utah	2,120	1,480 (6)	2,110	330	600	6,620
Wash.	2,120	1,660 (13)	2,620	300	600	7,300
Wyo.	2,140	1,480 (6)	1,920	360	560	6,470

*The methodology for estimating the average maternity cost for each state is found in Appendix 1 of the article beginning on page 103 of this issue.

†Numbers in parentheses refer to the method used for making estimates. For explanation, see Appendix 1, page 118.

‡Weighted by the number of Medicaid births in each state.

Note: Numbers may not add to totals because of rounding.

Table 3. Benefits and costs of a nonrestrictive policy for funding abortions, circa 1985

Region and state	No. of Medicaid abortions (1)	No. of Medicaid-funded births averted* (2)	Expenditures per abortion (3)	Medicaid expenditures for abortions (in $000s) (4)	Saving per birth averted (5)	Total saving from averted births (in $000s) (6)	Benefit-cost ratio (7)
U.S. total	**302,760–394,130**	**60,550–78,830**	**$315†**	**$95,462–$124,742**	**$6,750‡**	**$435,085–$540,362**	**4.3–4.6**
Northeast	**76,680–95,680**	**15,340–19,140**	**338†**	**25,948–34,070**	**6,820‡**	**102,324–125,568**	**3.7–3.9**
Conn.	1,850–4,570	370–910	191	353–873	7,320	2,705–6,687	7.7
Maine	700–2,430	140–490	292	206–709	6,170	870–2,998	4.2
Mass.	8,550	1,710	165	1,410	7,350	12,559	8.9
N.H.	270–1,040	50–210	292	78–304	5,220	277–1,088	3.6
N.J.	8,890	1,780	427	3,795	7,230	12,846	3.4
N.Y.	43,000	8,600	312	13,416	6,650	57,160	4.3
Pa.	11,950–24,210	2,390–4,840	524	6,259–12,687	5,870	14,024–28,425	2.2
R.I.	920–1,970	180–390	292	269–576	6,190	1,142–2,443	4.2
Vt.	560–1,030	110–210	292	163–300	6,630	741–1,362	4.5
North Central	**70,790–96,380**	**14,160–19,280**	**296†**	**20,963–28,456**	**6,130‡**	**88,380–119,140**	**4.2**
Ill.	19,390–20,940	3,880–4,190	292	5,661–6,115	5,410	20,969–22,649	3.7
Ind.	1,590–4,420	320–880	292	465–1,291	5,620	1,787–4,968	3.8
Iowa	1,070–3,600	210–720	292	312–1,051	4,780	1,022–3,439	3.3
Kans.	2,930–3,170	590–630	292	856–924	5,530	3,242–3,501	3.8
Mich.	19,570	3,910	308	6,028	7,070	27,671	4.6
Minn.	3,640–7,750	730–1,550	292	1,062–2,262	6,650	4,837–10,303	4.6
Mo.	1,860–5,020	370–1,000	292	544–1,465	5,220	1,945–5,239	3.6
Nebr.	1,110–1,640	220–330	292	325–480	5,810	1,294–1,909	4.0
N.Dak.	480–780	100–160	292	141–229	5,880	569–923	4.0
Ohio	10,440–19,560	2,090–3,910	292	3,048–5,712	6,550	13,672–25,621	4.5
S. Dak.	190–370	40–70	292	56–107	5,470	209–400	3.7
Wisc.	8,510–9,560	1,700–1,910	292	2,486–2,792	6,550	11,144–12,516	4.5
South	**45,280–87,010**	**9,060–17,400**	**285†**	**12,938–25,274**	**5,870‡**	**54,105–98,852**	**3.9–4.2**
Ala.	1,250–3,950	250–790	292	365–1,155	4,530	1,132–3,585	3.1
Ark.	900–870	180–510	292	263–751	5,760	1,036–2,963	3.9
Del.	780–800	160	292	227–235	5,960	928–959	4.1
D.C.	4,390	880	265	1,164	6,360	5,584	4.8
Fla.	6,620–7,720	1,320–1,540	292	1,934–2,253	6,450	8,538–9,948	4.4
Ga.	6,270	1,250	292	1,831	6,010	7,534	4.1
Ky.	2,020–12,150	400–2,430	292	589–3,549	4,850	1,959–11,795	3.3
La.	610–1,990	120–400	292	179–581	4,870	598–1,937	3.3
Md.	2,980–6,760	600–1,350	446	1,330–3,016	7,490	4,470–10,134	3.4
Miss.	750–3,160	150–630	292	220–924	4,400	662–2,786	3.0
N.C.	6,160	1,230	205	1,263	6,420	7,908	6.3
Okla.	1,020–4,250	200–850	292	299–1,240	5,300	1,085–4,502	3.6
S.C.	1,470–4,960	290–990	292	428–1,448	4,750	1,392–4,711	3.3
Tenn.	620–3,850	120–770	292	182–1,125	6,920	861–5,335	4.7
Tex.	4,100–8,810	820–1,760	292	1,198–2,573	5,510	4,523–9,711	3.8
Va.	4,660–5,290	930–1,060	292	1,359–1,544	5,700	5,303–6,024	3.9
W. Va.	670–3,910	130–780	159	107–621	4,400	592–3,436	5.5
West	**110,010–115,080**	**22,000–23,010**	**324†**	**35,582–36,943**	**8,380‡**	**190,276–198,801**	**5.3**
Alaska	310	60	756	233	11,340	699	3.0
Ariz.	990–2,560	200–510	292	290–748	5,980	1,187–3,057	4.1
Calif.	100,000	20,000	319	31,900	8,820	176,405	5.5
Colo.	1,740	350	256	444	5,910	2,049	4.6
Hawaii	1,790	360	664	1,191	7,230	2,593	2.2
Idaho	100–390	20–80	292	28–112	6,090	116–469	4.2
Mont.	400–850	80–170	292	116–249	6,590	523–1,124	4.5
Nev.	370	70	292	107	7,120	527	4.9
N.M.	350–870	70–170	292	104–253	6,760	479–1,171	4.6
Oreg.	530–1,740	110–350	192	102–335	6,910	733–2,413	7.2
Utah	230–1,110	50–220	292	68–323	6,620	311–1,465	4.5
Wash.	3,050	610	316	963	7,300	4,451	4.6
Wyo.	160–290	30–60	292	46–86	6,470	204–380	4.4

*Represents 20 percent of total number of abortions, on assumption that under a restrictive policy, only 20 percent of pregnancies would be carried to term.

†Weighted for number of abortions in each state. ‡Weighted by number of births in each state.

Note: Numbers may not add, multiply or divide to exact totals due to rounding.

ing that welfare recipients leave and return to the rolls at a constant rate, it was estimated that the family or child would require public assistance for an average of 15 months during the infant's first two years of life.

Next, an estimate was made of the average AFDC payments made over the first two years for old and new cases by applying appropriate monthly rates. For old cases, the state's average increment in scheduled "typical," or modal, AFDC monthly payments for FY 1986 was used. (For each state, the increments for different-sized families were weighted by the number of children in AFDC families in 1979.[28]) For new cases, the scheduled typical monthly payment for AFDC families with two recipients (assumed to be the child and one adult) was used. In order to derive the additional state and federal government welfare expenditures per birth, the resulting first two-year estimates were weighted by the proportions of births to women who were estimated to continue on public assistance and to start a new case (column 3). The average first two-year AFDC payments range from $620 in Mississippi to $3,810 in Alaska. The national average for all states is $1,890 per new child.

Food Stamps and WIC

The average public expenditure per new infant in the food stamp and WIC programs were similarly derived: Calculations were based on the proportion participating in the program, the duration of time spent in the program and the amount of monthly benefits.

To estimate the additional cost to the state for food stamps, national data were obtained from the 1985 CPS, which showed that 75 percent of Medicaid-eligible women were members of households receiving food stamps.[29] It was estimated that recipients remained in the food stamp program for an average of nine months.[30] Monthly food stamp benefits were not available by household size. An increase in benefits for the new person of $63 per month was assumed, the maximum increment in benefits when the number of persons enrolled in the program grows from two to three. Following the regulations for the food stamp program, the $63 in additional food stamp benefits was reduced (for old cases only) by 30 percent of the AFDC payment for the new baby. The estimated national average expenditures for food stamp benefits for a new baby is $310 in the first two years of the infant's life (column 4).

For the expenditures per newborn in the WIC program, it was assumed that all pregnant AFDC women participate in the program for some time, probably about six months on average, and that a baby receives benefits for about 12 months.[31] The average monthly cost per person (excluding 20 percent of total costs for program administration) was multiplied by the total number of months of enrollment to obtain the expenditures for a new baby in the WIC program. Nationally, the average WIC expenditures for the first two years of the infant's life is estimated at $590 per birth (column 5).

The last column of Table 2 shows that the average total cost to the state and federal governments of providing medical care and social welfare payments for a mother and a child in the first two years of the child's life is $6,750. The average is lowest in Mississippi and West Virginia ($4,400), and highest in Alaska ($11,340).

Births Averted

It has been estimated that in 1978, the year subsequent to the enforcement of the Hyde Amendment, about one-fifth of Medicaid-eligible women who would have obtained abortions prior to the Medicaid funding cutoff did not do so and, instead, carried their pregnancies to term.[32] As may be seen in column 2 of Table 3, if public funding for abortions had been available throughout the country, an estimated 61,000–79,000 births would have been averted among Medicaid-eligible women who did not want to have another child at that time. The figures represent one-fifth of the total estimated number of Medicaid-funded abortions shown in column 1, because only one-fifth of Medicaid-eligible women who want an abortion could be expected to carry their pregnancies to term. The other 80 percent would obtain legal abortions on their own or would miscarry. Although a very small proportion could be expected to have self-induced or illegal abortions, some of them would require Medicaid-funded treatment for resulting complications. Such numbers are believed to be small and are not considered in this analysis.

Benefits and Costs

The total savings in government expenditures from births averted because of publicly funded abortions is shown in column 6 of Table 3. The figure is derived for each state by multiplying the number of Medicaid-funded births that would be averted if funding restrictions on abortion were lifted (column 2) by the average public expenditure for births (column 5).

The total public expenditures for abortions under more liberal funding policies are shown in column 4. These are derived by multiplying the total estimated number of abortions that would be obtained by Medicaid-eligible women under more favorable conditions by the average public expenditure per abortion (columns 1 and 3). Finally, in column 7, the benefit-cost ratio is estimated for each state by dividing the total saving from the births averted under a nonrestrictive policy (column 6) by the total Medicaid expenditures for abortions (column 4). This figure can be interpreted as the number of dollars saved in public expenditures for every dollar spent on publicly funded abortions. The benefit-cost ratio for the nation as a whole and for each region cannot be obtained by averaging the state ratios because the national and regional expenditures shown in column 3 represent averages that are weighted by the number of abortions in each state. Rather, for the nation and the regions, the benefit-cost ratio is derived by dividing the total savings in column 6 by the expenditures for abortions shown in column 4.

Conclusion

Table 3 shows that if access to publicly funded abortions were available to indigent women who wanted to obtain them, federal and state medical and social welfare expenditures of $435–$540 million would be saved in the following two years—from 4.3 to 4.6 times the $95–$125 million in public funds that would have to be paid to fund abortions for Medicaid-eligible women. Were there no restrictions on public funding of abortions, the net savings in medical and social welfare costs would amount to $340–$415 million over the following two years. The net saving in the Medicaid program would be at least $194 million, and the net savings in the social welfare programs would be at least $146 million (not shown).

Thus, for every public dollar spent to pay for abortions for poor women, more than four dollars is saved in medical and social welfare costs over the next two years. Massachusetts, with the highest ratio (8.9:1.0), would benefit most. Hawaii and Pennsylvania, with their relatively high per-abortion costs, have the lowest ratio; but even in these states, at least two dollars in public expenditures would be saved for each dollar spent by government to pay for abortions for poor women.

The decision to provide public funds to pay for abortions for indigent women is based mainly on principles of fairness and equity. Poor women should have the same right to terminate an unintended pregnancy that more affluent women have. Without access to subsidized abortion services, however, a substantial proportion of poor women are unable to exercise this right. An analysis of the 1984 Colorado referendum campaign showed that many voters who are not opposed to abortion nevertheless voted against

state payments for abortion because they perceived that such funding resulted in increased taxes.[33] In fact, the reverse is true. The data presented in this article show that the savings to taxpayers from paying for abortions is substantial.

Public funding of abortion, therefore, has two beneficial results: It saves money at the same time that it helps to ensure that poor women have control over their childbearing, so that they will not be forced to bear and take responsibility for raising children at a time when they do not wish or are not prepared to do so.

Appendix 1. Methodology For Estimates in Table 2

Unless otherwise stated, reimbursement rates were applied to national infant care utilization data estimated for a child aged 0–1 (excluding newborns)—an average of seven pediatric visits, two days in hospital care for illness and injury, and 1.1 days in neonatal intensive care.

1. Based on reported reimbursement rates.

2. Based on reported reimbursement rate for a pediatric visit and average per diem hospital rates for all reporting states.

3. Based on reported reimbursement rate for a pediatric visit, average per diem hospital rates for all reporting states and reported percentage of infants in neonatal intensive care.

4. Based on reported per diem hospital reimbursement rates and average rates for a pediatric visit for all reporting states.

5. Based on reported reimbursement rate for a pediatric visit, expenditures on neonatal intensive care and average per diem hospital rates for illness for all reporting states.

6. Based on average reimbursement rates for all reporting states.

7. Based on reported reimbursement rate for a pediatric visit, per diem hospital rate for illness and expenditures for neonatal intensive care.

8. Based on reported reimbursement rate for a pediatric visit, hospital discharge rate for illness and expenditures for neonatal intensive care.

9. Reported expenditures for pediatric care and hospital care for illness, and average per diem hospital rates for neonatal intensive care for all reporting states.

10. Based on reported expenditures for neonatal intensive care, and average pediatric visit and per diem hospital reimbursement rates for all reporting states.

11. Based on reported reimbursement rate for a pediatric visit and rate per hospital discharge for illness, and average per diem hospital rates for neonatal intensive care for all reporting states.

12. Reported expenditures for infants under age one and one-fifth of expenditures for infants aged 1–5.

13. Reported total expenditures for infant care.

14. Reported expenditures for neonatal intensive care, and reimbursement rates per hospital discharge for illness, and average rate for pediatric visit for all reporting states.

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Abortion Attitudes and Performance Among Male and Female Obstetrician-Gynecologists

By Carol S. Weisman, Constance A. Nathanson, Martha Ann Teitelbaum, Gary A. Chase and Theodore M. King

Summary

Recently trained female obstetrician-gynecologists in active practice have more favorable attitudes toward abortion than do recently trained male ob-gyns, and the former also are more likely to provide abortions. However, since female providers perform fewer abortions than do male providers, women's contribution to the overall volume of abortions performed is no higher than expected. In a multivariate analysis, abortion attitudes proved to be the strongest predictor of whether or not a physician provides abortions, but practice-related variables are stronger predictors of the *number* of abortions performed. Factors related to policy issues, such as state funding of abortions for poor women and hospital policies with respect to abortion provision, had statistically significant effects on physicians' abortion performance.

Introduction

During the past decade, female graduates of U.S. medical schools have entered obstetrics and gynecology in greater numbers than they had previously;[1] they now constitute 42 percent of all residents in the specialty, as compared with only 15 percent 10 years ago.[2] A 1981 survey of first-year residents in obstetrics and gynecology found that women were significantly more likely than men to report that they entered the specialty because of an interest in feminism or a desire to improve the health care of women. These women were also more likely than men to agree that "abortion services should be available on request."[3] A 1985 survey of 1,300 members of the American College of Obstetricians and Gynecologists (ACOG) found that female physicians of all ages were more likely than males to believe that abortions are justified under some circumstances.[4]

As greater numbers of women take up the specialty of obstetrics and gynecology, their more favorable attitudes toward abortion could improve access to abortion services by increasing the proportion of physicians who perform the procedure. Female ob-gyns might also affect the delivery of services by improving the conditions under which abortions are provided. For example, they might be more sympathetic to their patients' needs and less judgmental. There is some research evidence that women doctors are in general more empathetic than men, but this finding has not been investigated specifically with respect to delivery of abortion services.[5] Female physicians might also be more likely than men to oppose the use of consent or notification procedures, or other restrictions on patients' access to abortion services.

However, while women ob-gyns may be more likely than their male colleagues to provide abortions or to support access to abortion, they may not perform as many abortions as male providers if traditional sex differences in professional productivity apply to this specialty. Previous research has shown that female physicians do not work as many hours per week or see as many patients as males, although recent studies show that this gap is narrowing.[6] Thus, gender differences in practice patterns might offset the effects of women's more favorable attitudes toward abortion.

Methodology

In 1984, we conducted a national survey of practicing ob-gyns in order to investigate attitudes toward and delivery of various fertility-control services, including abortion. The survey involved a disproportional stratified sample of male and female ob-gyns who were members of the ACOG and who had graduated from medical school between 1974 and 1979 (the period of greatest increase in the number of women entering the specialty).* The sample consisted of all women who met these criteria (930 in all) and an equal number of men, who were chosen through a 28 percent systematic sample. Subjects were contacted by telephone and screened to ensure that they had completed a residency program in the specialty and were in current active practice, on at least a part-time basis, in the United States. Only 14 percent (253 subjects) refused to participate; 15 subjects could not be located. In addition, 11 percent of the remaining subjects were found to be ineligible, in 95 percent of the cases because they were still in full-time residency or subspecialty training. Reasons for ineligibility did not differ by sex.

Subjects were first interviewed by telephone about their practices and the services they provided, then were sent a questionnaire consisting primarily of attitude measures. The response rate on the telephone interviews was 84 percent (1,420 practitioners, of whom 714 were women). Among the interview respondents, 84 percent completed the questionnaire, for an overall response rate of 70 percent on both instruments. The response rates did not differ significantly by

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*Analyses by the ACOG show that among those who completed residencies in obstetrics and gynecology, there is no difference in the rates at which male and female physicians join the association. By the time they become board-certified in the specialty, 90 percent of ob-gyns have joined (see reference 2). The ACOG sampling frame, therefore, provides an appropriate population of formally trained specialists who are or intend to become board-certified.

Table 1. Percentage distribution of ob-gyns, by whether they strongly agree, somewhat agree, somewhat disagree or strongly disagree with various abortion attitudes, according to gender of ob-gyn*

Attitude	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Total	N
Women should have the legal right to obtain abortions						
Male	76	15	4	5	100	702†
Female	90	6	1	3	100	710†
When a woman requests an abortion, there should be a mandatory waiting period before the abortion is performed						
Male	7	21	28	44	100	572
Female	5	16	24	55	100	609
Unmarried minors should be required to obtain consent from their parent or guardian before obtaining an abortion						
Male	10	18	24	48	100	573
Female	7	8	21	64	100	608
Public funding [Medicaid] should not cover abortion services						
Male	17	13	29	41	100	574
Female	8	7	20	64	100	608

*All gender differences are statistically significant at $p<0.05$, by the chi-square test.

†These Ns are higher than the others because the item on legal abortion appeared in the telephone interview; the remaining items appeared on the mailed follow-up questionnaire. Respondents to the mailed questionnaire did not differ from nonrespondents with respect to their attitude toward legal abortion.

sex, and response to the questionnaire did not vary by measures of abortion performance or attitudes included in the interview. Therefore, we can detect no response biases that would affect the present analysis.

The respondents were located throughout the United States and, by virtue of having recently completed training, had been in practice an average of three years. Consistent with the pattern for ob-gyns in general, the respondents were practicing predominantly in small ob-gyn partnerships (43 percent of the men and 33 percent of the women) or in private solo practices (26 percent and 23 percent, respectively). The remaining respondents were practicing either in multispecialty groups (14 percent of the men and 22 percent of the women) or in institutional settings, in positions that tend to be salaried (17 percent of the men and and 22 percent of the women). These primarily involve faculty positions in medical schools and staff positions in hospitals. The practice patterns of the respondents studied here have been described in more detail elsewhere.[7]

Abortion Attitudes

Table 1 shows the responses that ob-gyns gave to four questions on attitudes toward legal abortion and toward certain types of restrictions on access to the procedure: mandatory waiting periods, parental consent requirements and the absence of public funding for abortions. The findings show that the respondents overwhelmingly hold attitudes supportive of the availability of abortion: Ninety-one percent of the men and 96 percent of the women agree or strongly agree that women should have the legal right to obtain abortions, and well over two-thirds of all respondents disagree with the various restrictions on access to abortion. However, on all four items, higher proportions of women than of men report strongly favorable attitudes, and these gender differences are statistically significant ($p<0.05$). For example, 90 percent of the women strongly agree that a woman should have the right to an abortion, compared with 76 percent of men. Similarly, 64 percent of women strongly disagree that public funding should not cover abortion services, compared with 41 percent of men. Thus, women in this survey are more strongly supportive than men of unrestricted access to abortion services.

Table 2 shows a similar pattern in responses to a question asking whether the respondent has any personal ethical reservations about performing abortions during the first trimester. (For each of eight conditions cited, the respondent was asked to indicate whether he or she has strong, moderate or no ethical reservations.) All respondents were asked this question whether or not they actually perform abortions. Both men and women are highly unlikely to have ethical reservations when either a pregnant woman's health or the health of the fetus (such as in the case of a serious fetal genetic defect) is endangered, and are considerably more likely to have reservations when a pregnant woman's psychological state or social circumstances are the reasons for the abortion.

However, larger proportions of female ob-gyns than of men report no ethical reservations in all circumstances, and larger gender differences occur for the conditions that evoke stronger ethical reservations. For example, when the life of the pregnant woman is endangered (the condition least likely to evoke ethical reservations), men and women differ by only five percentage points in the proportions reporting no reservations. However, when the woman is married and does not want more children (the condition most likely to evoke ethical reservations), a difference of 18 percentage points separates men and women. Overall, when the degree of ethical reservations is summed across all eight conditions, women are significantly more likely than men to have no ethical reservations about performing first-trimester abortions: 61 percent vs. 41 percent. The mean scores shown at the bottom of Table 2 indicate that overall, female ob-gyns have fewer ethical reservations about performing abortions than do male ob-gyns (10.5 compared with 12.2, significant at $p<0.001$).

Although numerous public opinion polls have included items to determine the acceptability of abortion under conditions similar to those used here, direct comparisons between the results of such polls and the answers provided by physicians are difficult, because different premises underlie the two sets of questions. In the public polls, respondents are asked whether they believe a woman should be able to obtain a legal abortion under each condition; here, the physician is reporting whether he or she has any personal ethical reservations about *performing* an abortion under each condition. Given this caveat, female doctors in this study appear to be more supportive of abortions than the general public on four out of five conditions for which comparisons are available (based on a 1985 National Opinion Research Center survey).[8] Most notably, whereas over 60 percent of women ob-gyns report that they would have no ethical reservations about performing abortions when a family is poor and cannot afford more children, or when a woman is married and does not want more children, the public approves of legal abortions under such conditions at rates of only 44 percent and 40 percent, respectively. In these cases, while male physicians are less favorable about abortion than are female ob-gyns, the men remain more supportive of abortion than is the general public.

It is also noteworthy that in public opinion

polls, the association between gender and abortion attitudes is generally not significant, although in a few cases men hold slightly more favorable attitudes toward abortion than women.[9] This finding contrasts with the results of the present study and of the recent ACOG survey noted earlier, in which women ob-gyns are more supportive of abortions than are men. These results are consistent with the hypotheses that women with more favorable abortion attitudes are selected into obstetrics and gynecology or that female physicians become more sensitive than men to abortion issues in the course of their training or practice.

Some of the same factors that determine the public's attitudes toward abortion also affect physicians' attitudes. To explore what factors other than gender might account for the degree to which ob-gyns have ethical reservations about performing abortions, we performed a multiple regression analysis in which the ethical reservations scale was regressed on a number of social and demographic variables.* Taken together, these characteristics account for 28 percent of the variance in ethical reservations. The strongest predictors are religion and religiosity: Catholic doctors (representing 24 percent of the men and 17 percent of the women) and those who report that religion is very important to them expressed greater ethical reservations about abortion. (Being Catholic and reporting religion to be "very important" are correlated, $r = +0.14$, $p<0.001$.) Being male and practicing in a rural area are other statistically significant, but weaker, predictors of ethical reservations. The age and race of a physician are not significant predictors, although the restricted age range in this sample may account for the absence of the former relationship. Thus, among the ob-gyns studied here, abortion attitudes appear to be primarily a function of religious values, although the impact of the religion variables does not account totally for the difference between the abortion attitudes of male and female doctors.

Table 2. Percentage of ob-gyns who would have no ethical reservations about performing first-trimester abortions under specific conditions, and mean score on ethical reservations scale,† by gender

Condition	Male (N=567)	Female (N=603)
The life of the mother is endangered by the pregnancy*	86	91
The mother's health is seriously endangered by the pregnancy*	81	89
There is a strong chance of serious genetic defect in the fetus*	79	88
The pregnancy resulted from rape or incest*	74	86
The mother's psychological well-being is seriously endangered by the pregnancy*	57	73
The mother is an unmarried teenager*	51	68
The family is poor and cannot afford more children*	49	66
The mother is married and does not want more children*	45	63
Mean score on ethical reservations scale**	12.17	10.47

*Responses are significantly different, $p<0.05$, according to the t-test.

**The means are significantly different, $p<0.001$, according to the t-test.

†For each condition, respondents were asked to indicate whether they had strong personal ethical reservations about performing an abortion, moderate reservations or no reservations. The mean score was calculated by averaging the scale scores—the sum of reported replies for each respondent. Strong reservations received a score of 3, moderate reservations, a score of 2, and no reservations, a score of 1. Thus, the scores could (and did) range between 8 and 24, with a higher score indicating greater overall ethical reservations about abortion. The modal score was 8.

Table 3. Percentage of ob-gyns who performed at least one abortion in the 12 months preceding the survey, and mean numbers of abortions performed during that time by providers and by all respondents, by gender

Measure	Male	Female
Abortion providers		
%	42.9	50.5*
N	706	711
Abortions performed by providers†		
Mean no.	89.5	72.7
Standard deviation	195.7	162.7
N	300	355
Abortions performed by all respondents†		
Mean no.	38.3	36.4
Standard deviation	135.5	120.2
N	699	707

*Gender difference is significant at $p<0.05$ using chi-square test.

†To determine the significance of gender differences, t-tests were computed for both the actual number of abortions and the logarithm of the number of abortions; none of the differences were statistically significant.

Performance of Abortions

Given that women ob-gyns hold such favorable attitudes toward the availability of abortion services, are they also more likely than men to perform abortions in their own practices? Two aspects of abortion performance are considered—whether or not the physician provides abortions, and the volume of abortions per provider. Respondents were asked whether they had performed any abortions during the previous 12 months and, if so, how many. For purposes of this analysis, any ob-gyn who performed at least one abortion (either first- or second-trimester) during the previous year is classified as an abortion provider.

As Table 3 shows, 43 percent of male and 50 percent of female ob-gyns report that they provided at least one abortion during the year—a small but statistically significant gender difference. (Most of these respondents provided first-trimester abortions only; 19 percent of men and 22 percent of women report that they performed any second-trimester abortions—a difference that was not statistically significant.)

Before we examine differences in the number of abortions performed, it should be noted that the distribution of the number of abortions reported by providers is highly skewed and reveals considerable variation (as indicated by the large standard deviations in Table 3). Most respondents perform very few abortions, but some respondents do a large number of them. For both sexes, the median number of first-trimester abortions performed by providers was 20; the median number of second-trimester abortions was five among the men and three among the women. However, 10 women and 15 men report that they performed more than 500 abortions during the year. Thirty-two percent of both male and female providers (212 respondents) report having performed 50 abortions or more during the previous year; this number is equivalent to at least one abortion per week of practice, since ob-gyns in this study practice an average of 11.5 months per year. However, abortion clearly does not constitute a large part of the practices of the majority of the subjects in this study.

Table 3 shows two different ways of comparing the volume of abortion services performed by male and female practitioners. Among those who provided any abortions, men performed an average of 90 first- and second-trimester abortions during the year, compared with 73 abortions among women. (Although the average varies substantially between the sexes, this difference is not statistically significant, because of the large standard deviations. Furthermore, it is not a valid measure of an overall gender difference in the number of abortions performed, because it is not adjusted for the relative proportion of men and women who provide abortions.) The last panel of Table 3 compares the mean numbers of abortions, computed for all male and female respondents, including those who performed no abortions during the previous year. The means are quite similar—38 for the men and 36 for the women—and represent a more important in-

* These variables were gender, age, race, religion, religiosity and practice location.

Table 4. Percentage of ob-gyns who performed at least one abortion in the 12 months preceding the survey, and mean number of abortions performed by ob-gyns who provide abortions, by gender, according to principal type of practice arrangement

Measure	Total	Private solo	Ob-gyn partnership	Multispecialty group	Institutional position
Abortion providers					
Male					
%	42.9	50.8	40.8	50.5	30.3
N	706	181	304	99	122
Female					
%	50.5	50.0	54.4*	48.4	47.1*
N	711	166	237	155	153
No. of abortions performed by providers					
Male					
Mean	89.5	123.3	70.3	74.3	92.5
N	300	89	124	50	37
Female					
Mean	72.7	143.2	50.6	47.4	58.9
N	355	80	129	74	72

*Gender difference is significant at $p<0.05$ using chi-square test.

dicator of the relative contribution of both sexes to the total volume of abortion services. In sum, women who provide abortions do so at a lower volume than male providers, but the higher proportion of women who provide abortions compensates almost exactly for this difference.

To verify this conclusion, we used standard formulas for estimating population totals from a stratified sample. The results show that the estimated fraction of abortions performed by all women ob-gyns was approximately 20.6 percent, while women represent 21.3 percent of all physicians in this population. This finding provides further substantiation that female physicians' contribution to the total volume of abortion services is proportional to their representation.

Factors Associated With Abortion Performance

Using multiple regression analysis,* we next considered how such factors as abortion attitudes, physician's gender and type of medical practice are associated with the performance of abortions. The physician's principal practice arrangement was considered to be a potentially important influence on the performance of abortions, for a number of reasons. Ob-gyns in solo practice were expected to have performed more abortions, because of financial incentives (which may be especially salient for doctors in the early stages of establishing a practice), the degree to which the doctor-patient relationship is personal and continuous, and the physician's degree of autonomy in determining which services to provide and at what volume. In group or institutional practices, on the other hand, administrative constraints would be expected to lower abortion performance.

Table 4 shows that physicians in private solo practices are not necessarily more likely than others to provide abortions. However, among abortion providers, those in private solo practices perform by far the highest numbers of abortions. In such practice, furthermore, women tend to perform more abortions than men (143 compared with 123), although the difference does not reach statistical significance. In contrast, men perform more abortions than women in all other practice arrangements. The lowest proportion of ob-gyns providing abortions was among men working in institutional practices (30 percent); this small proportion is probably due to the fact that one-third of these men practice in military hospitals.

We expected that the number of hours worked per week and the number of years spent in practice would be related to abortion performance and might account for the lower overall number of abortions performed by women. However, women were found to work only 5.5 fewer hours than men each week, on average, and no association was found between the number of hours worked and the number of abortions performed. In multiple regression equations not discussed here, the number of hours worked had no impact on either abortion provision or the number of abortions performed. Similarly, the number of years spent in practice was not associated with the performance of abortions. These variables are therefore omitted from the regression analyses that are reported here.

Different types of practice settings were also considered in relation to abortion performance. One variable measured whether a physician spent any time working in a freestanding family planning or abortion clinic, where most abortions are performed.[10] In this sample, 11 percent of women and 13 percent of men report that they practice in a freestanding clinic (all but two on a part-time basis). Another variable measured whether or not the hospital in which a physician has his or her primary affiliation (i.e., where he or she admitted the most patients during the previous year) provides elective abortions as a matter of policy. In this sample, 53 percent of women and 43 percent of men report that their primary hospital provides abortions; this difference is statistically significant at $p<0.05$.

An additional relevant variable is one indicating whether demand for abortion services is likely to be high in the locale in which a physician practices. Several possible indicators of abortion demand were considered for analysis, including the region of the country, a categorical variable based on the 1982 abortion rate in the state where the physician was practicing in 1984, whether or not the state provides public reimbursement (usually Medicaid funding) for abortions obtained by low-income women,† urban or rural location of the practice, and whether or not the physician treats unmarried teenagers (who are important users of abortion services).

Since ob-gyns in this study were identified by state, we decided to use state-specific data rather than the broader regional classifications that in some cases mask state differences in abortion rates.[11] In regression analyses not reported on here, we found that a state's funding of abortions is a consistently significant predictor of abortion performance by physicians, whereas the state's relative abortion rate is not. Consequently, the funding variable was retained for analysis and the state abortion rate was omitted. In this sample, 55 percent of women and 41 percent of men practice in states that offer public funding for abortions; this difference is largely attributable to the fact that in this sample, there is a greater proportion of women than men practicing obstetrics and gynecology in California, New York and Pennsylvania.

Practice locations were categorized as highly urban (large cities and their suburbs), moderately urban (medium-sized cities and their suburbs) or rural (small cities or towns, as well as actual rural areas). Sixteen percent of women and 22 percent of men practice in rural areas, where abortion demand is lower than in more highly urbanized areas. Finally, 83 percent of women and 73 percent of men report that they provided abortions to unmarried teenagers "very often" or "often" (as opposed to "rarely" or "never") during the past year.

We also examined religion and religiosity in relation to abortion performance. As noted

*Standardized partial regression coefficients (betas) that are obtained in a multiple regression are indicators of the relative strength of a given variable when the effects of other variables have been taken into account. Each coefficient can be interpreted as representing the effect of that variable adjusted for the impact of all other predictor variables. In addition, the R^2 obtained for a regression equation shows the proportion of variation that is explained by all of the variables that have been considered.

†At the time of this study, 15 states (Alaska, California, Colorado, Connecticut, Hawaii, Maryland, Massachusetts, Michigan, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Washington and West Virginia) and the District of Columbia provided either Medicaid funding or some other source of funding for abortions among low-income women. Ten of these states had 1982 abortion rates higher than the national rate of 25.5 abortions per 1,000 women aged 15–44 (see reference 10).

earlier, being Catholic and reporting that religion is very important are the strongest factors determining whether ob-gyns have ethical reservations about performing abortions. However, in this sample, ethical reservations are more strongly correlated with the fact that abortion is provided in the practice ($r=-0.43$, $p<0.001$) than is either being Catholic ($r=-0.24$, $p<0.001$) or being very religious ($r=-0.24$, $p<0.001$). In multiple regression analyses not reported on here, we found that being Catholic and being religious are significantly and negatively related to the provision of abortions when the scale of ethical reservations is omitted from the analysis. However, the inclusion of ethical reservations significantly increases the amount of variance explained, and substantially reduces the value of the coefficients for religion and religiosity. Furthermore, when the measure of ethical reservations is included in the equation, religion and religiosity do not contribute significantly to the overall amount of variance explained. These findings support the interpretation that religion and religiosity affect abortion performance primarily through their effect on abortion attitudes; thus, religion variables are omitted from subsequent analyses of abortion performance.

The first three columns of Table 5 show the results of multiple regression analyses in which the dependent variable is whether or not a physician performed any abortions during the year prior to the study. An analysis was performed first for all male and female ob-gyns (so the impact of a physician's gender could be measured in relation to that of the other variables), and then separately for men and women (in order to determine whether the findings are different for the sexes). The R^2s in Table 5 show that a high proportion of variance is explained in all three analyses, and that prediction is somewhat better for men than for women.

The analysis for all ob-gyns shows that the standardized partial regression coefficient for the physician's gender is weak (−0.04) and thus has no effect on the provision of abortion when covariates are taken into account. The most important predictor is the physician's degree of ethical reservations: Doctors with stronger reservations are significantly less likely to provide abortions, even after gender and practice variables are controlled for.* The second-strongest predictor is whether or not the physician's primary hospital provides abortions: Ob-gyns with admitting privileges at such hospitals are more likely to perform abortions, although these data do not indicate whether the physicians actually perform any abortions in these hospitals. The third-strongest predictor is the availability of state Medicaid or other public funding for abortions. Other, weaker but statistically significant predictors of abortion performance are holding an institutional staff position (i.e., ob-gyns working in private solo practice are significantly more likely to provide abortions than are ob-gyns in institutional practice), working in a freestanding clinic and treating unmarried teenagers.

Table 5. Multiple regression analyses of abortion provision and of number of abortions performed by providers

Variable	Abortion provision†			Number of abortions performed‡		
	Total*** (N=1,158)	Male*** (N=564)	Female*** (N=594)	Total*** (N=535)	Male*** (N=239)	Female*** (N=296)
Sex (female)	−0.04	na	na	−0.05	na	na
Ethical reservations	−0.36*	−0.39*	−0.31*	−0.11*	−0.14*	−0.08
Practice type§						
Partnership	0.00	−0.04	0.05	−0.13*	−0.17*	−0.11
Multispecialty group	−0.05	−0.03	−0.05	−0.17*	−0.23*	−0.14
Institutional	−0.09*	−0.13*	−0.04	−0.13*	−0.14	−0.12
Works in freestanding clinic	0.07*	0.07*	0.07*	0.22*	0.22*	0.22*
Primary hospital provides abortions	0.26*	0.30*	0.20*	0.13*	0.04	0.18*
State provides reimbursement	0.13*	0.12*	0.15*	0.13*	0.10	0.16*
Rural practice	−0.05	−0.04	−0.06	−0.06	−0.18*	0.00
Treats unmarried teenagers	0.06*	0.08*	0.05	0.09*	0.20*	0.02
R^2	0.301	0.359	0.249	0.143	0.189	0.143

*Statistically significant at $p<0.05$, according to univariate F-test.

***Overall F statistic is significant at $p<0.001$.

†Abortion provision, the dependent variable, is a dichotomous variable that is coded "1" if the respondent reported that he or she performed at least one abortion during the previous 12 months, and is coded as "0" otherwise.

‡The number of abortions performed, the dependent variable, is the natural logarithm of the total number of abortions performed in the previous 12 months by all respondents who said that they performed abortions.

§The practice type variables are dummy variables representing the respondent's principal practice arrangement, with private solo practice serving as the reference category.

Note: na = not applicable.

As the table also shows, the pattern of prediction is virtually identical for men and women, with one exception. Practicing in an institutional setting reduces the likelihood of providing abortions among male ob-gyns, but not among female practitioners. (This finding is consistent with data in Table 4.) For both sexes, the single most important predictor of whether a doctor provides abortions is the degree of ethical reservations about abortions; because women are less likely than men to report ethical reservations, this variable largely accounts for the sex difference in provision of abortions observed in Table 3.

Results of a similar multiple regression analysis of the *number* of abortions performed by those who provide abortions are also shown in Table 5.† The R^2s in this analysis are lower than those in the previous one, indicating that less variance is explained. The analysis for all ob-gyns shows that a physician's gender fails to exert a significant effect on the number of abortions performed. Nonetheless, the last two columns in the table show that the prediction models differ by physician's gender. The strongest predictor of the number of abortions performed by men is whether they practice in a multispecialty group (which has a strong negative effect on abortion volume). Practicing in an ob-gyn partnership also has a significant negative effect on the number of abortions performed, which is consistent with the findings in Table 4. The second-strongest predictor

*The scale of ethical reservations, rather than the other measures of abortion attitudes, is used for these analyses because all of the single-item attitude measures are highly intercorrelated with the ethical reservations scale, and the scale has the strongest correlation with abortion performance.

†In order to use the number of abortions performed as a dependent variable, it was necessary to mathematically transform the variable to approximate a normal distribution. This was accomplished by using a logarithmic transformation of the number of abortions performed. We also generated multiple regression equations by using a categorized form of the dependent variable (contrasting high-volume performers with low-volume performers), but the results were substantially the same as those reported here.

for men is whether they work in a freestanding clinic, followed by whether they treat unmarried teenagers. Practicing in a rural area significantly reduces abortion volume among men, as does having ethical reservations about abortion.

For female ob-gyns, the picture is quite different. Only three variables are significantly related to an increased abortion volume—working in a freestanding clinic, being affiliated with a hospital that provides abortions and practicing in a state that provides public funding. Private solo practice increases abortion volume, but the comparisons with other practice types do not reach statistical significance. The degree of ethical reservations is also not a statistically significant predictor of abortion volume for women. Thus, women ob-gyns' more favorable abortion attitudes do not result in a dramatically higher volume of abortions performed by women who provide these services.

It may be that a female ob-gyn who has the most positive abortion attitudes, having decided to perform abortions, provides them at a higher volume if she practices in a favorable climate. The abortion policy of her primary hospital, her practice in a freestanding clinic and her practice in a state that funds abortion may all be construed as indicators of a climate supportive of abortion services (discussed further below). Male abortion providers, however, appear to respond more to the demand for abortion services and to the financial incentives inherent in specific types of practices. Men practicing in ob-gyn partnerships or multispecialty groups have less financial incentive than those in private practice to provide more abortions, because abortion fees are shared or returned to the group. Thus, men with the least financial incentive to provide more abortions (i.e., those in fixed-salary positions) are seen in Table 5 to be less likely to provide abortions at all.

However, an interpretation of the abortion volume of male ob-gyns cannot rest entirely on assumptions about financial incentives, since men's degree of ethical reservations also exercises a significant influence on the number of abortions that they provide. Furthermore, the degree to which providers increase volume as a function of more favorable abortion attitudes is more pronounced among men than among women. The most likely explanation for this finding is that there is less variation in women's abortion attitudes than in those of men; because there is a wider divergence of attitudes among men, their attitudes affect the volume of services provided. Nevertheless, characteristics of the practice and environment are more important than abortion attitudes in predicting the number of abortions performed.

Discussion

The implications for abortion services of the increasing proportion of women practicing obstetrics and gynecology are twofold. First, the greater number of female ob-gyns is likely to improve the accessibility of abortion services, by increasing the proportion of ob-gyns who will provide the service. Second, the increasing proportion of women ob-gyns is not likely to have an impact on the overall volume of abortions provided.

This study has focused on ob-gyns who completed medical school and residency training after 1973 (the year that the U.S. Supreme Court legalized abortion), and who therefore are most likely to have been exposed to training programs that included abortion procedures and to practice settings in which elective abortions were considered legitimate services. Yet, consistent with research on the performance of abortions during the mid-1970s,[12] the findings of this study show that personal attitudes favorable to abortion are strongly associated with the provision of abortions. Apparently, abortion in the United States remains a controversial service that is provided (or not provided) largely at the discretion of the physician.

However, even if doctors' attitudes toward abortion were immutable, the findings here suggest that abortion performance might be influenced in several ways. State funding of abortions for low-income women has been shown to be a significant predictor of an individual's provision of abortion and of the *number* of abortions provided by women, net of the effect of other variables. However, this does not mean that the main influence is financial. Our data show that state funding of abortions is associated with higher rates of abortion provision even among physicians who report that they "rarely" or "never" treat Medicaid patients; in states that fund abortions through Medicaid, 59 percent of doctors who do not treat Medicaid patients provide abortions, whereas in states that do not fund abortions through Medicaid, 32 percent do so (statistically significant at $p<0.05$). Thus, state funding appears to have an effect on abortion provision whether or not ob-gyns take advantage of the Medicaid reimbursement. Consequently, an alternative interpretation of the influence of state funding would be that it reflects a social climate more supportive of abortion, in which both doctors and patients are likely to feel more comfortable about the service. Thus, it would not be state funding per se that affects physician behavior, but rather the social climate associated with a state's decision to provide Medicaid reimbursement for abortion.

Hospital policies were also found to be an important predictor of whether or not a doctor provides abortions (and, among women, of the number of abortions provided). This may seem surprising, since most abortions are not performed in hospitals: In 1982, 82 percent of abortions were performed in nonhospital facilities, and hospitals represented just 48 percent of the facilities where abortions were performed.[13] However, one study found that hospital climate (measured as the aggregate attitudes of obstetricians affiliated with a hospital) affects both abortion performance and the likelihood that a physician accepts abortion referrals.[14] In the present study, the abortion policy of the ob-gyn's primary hospital may be interpreted as reflecting the colleague climate in which he or she practices, as well as the degree to which the physician has an opportunity to provide abortions within the hospital or elsewhere.

Of course, it is possible that rather than determining the physician's abortion performance, some of the practice-related characteristics studied here might reflect the physician's selection of a practice setting compatible with his or her abortion preferences, or might reflect the physician's influence on the practice site. For example, a physician might become affiliated with a hospital, choose to work in a freestanding clinic or even select a state in which to practice because of his or her intentions to perform or not perform abortions. Alternatively, a physician might actively influence the abortion policy of the hospital, clinic or state.

The causal ambiguity inherent in these processes cannot be resolved in this cross-sectional study. However, if the selection effect were strong, we would expect to find strong correlations between the abortion attitudes of ob-gyns and the policies of their hospitals or states. Instead, the correlations in this study between abortion attitudes and the abortion policies of respondents' hospitals and states are weaker than the correlations between those policies and abortion performance. Thus, it is very possible that institutional and state policies, independent of a physician's own attitudes, influence a physician's behavior with respect to abortion.

In addition to its cross-sectional design, another limitation of this study is that its findings cannot confidently be generalized to future ob-gyns. This study has focused on recently trained ob-gyns, who entered the specialty during an era in which women with a feminist orientation or a concern for reforming medical practice may have been more likely than other women to become ob-gyns. It is not clear whether the gender differences observed here will continue as these physicians age or will be replicated in future cohorts of ob-gyns.

Finally, gender differences in the attitudes

measured in this study imply that women may be more responsive than men to patients who request abortions, and may be more likely to oppose restrictions on access within their practices (e.g., waiting periods or consent or notification requirements). Hence, they are likely to provide abortions in a more supportive atmosphere than men. The present study has not observed women and men in their direct interactions with patients or measured the differential responses of patients to care given by male and by female physicians, but this would be a useful approach for future research on the topic.

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DIGEST

Average of 63% Approve Of Legal Abortions; No Change over 15 Years

Levels of approval of legal abortion have remained almost unchanged during the last 15 years. In 1987, according to the most recent survey taken by the National Opinion Research Center (NORC), approval among adult Americans ranges from 40 percent—for an abortion obtained for any reason—to nearly 90 percent if the pregnancy would seriously endanger the woman's health. There is virtually no difference in approval between Catholics and Protestants, but individuals who report low levels of religious commitment are considerably more likely to approve than are those who report high levels. Approval is also substantially higher among people with some college education than among those with less than a high school education. Whites are somewhat more approving than blacks. Adults under age 30 are slightly more likely to approve of abortion than are those over age 65, and men are slightly more likely than women.[1]

The NORC first asked adult Americans in 1965 whether they thought it should or should not be possible for a pregnant woman to obtain a legal abortion under six circumstances. The six reasons ranged from serious health endangerment to the desire to have no more children. The NORC then repeated the survey (as part of its General Social Survey) in 1972 and every year thereafter except 1979, 1981 and 1986. Since 1977, it has asked respondents a seventh question—whether they approve of legal abortion "for any reason." The 1987 abortion questions were addressed to 1,466 persons aged 18 and older. Since 1972, the NORC has queried a total of 21,168 Americans about their abortion attitudes.

Table 1 shows the proportions approving of legal abortion for various reasons in 1987, 1985 and 1972 and the average proportions doing so over the 16-year period. In 1987, the average level of approval for *all* reasons combined is 63 percent, not much different from the 62 percent who approved in 1985; however, the 1987 approval level is four points higher than that of 1972, the year before the Supreme Court outlawed restrictive state abortion laws. For the entire period 1972–1987, the average approval rate for all reasons is 66 percent.

The largest difference between 1987 and 1985 is in the level of approval for *any* reason—40 percent vs. 37 percent, respectively. During the last 10 years, the rate of approval for any reason has averaged 38 percent. Since 1972, the proportions approving of abortion have increased or decreased only slightly; and in only two cases are the approval rates in 1987 a little lower than they were in 1972—when the reason for the abortion is that the woman is poor and can't afford another child, and when she is unmarried and unwilling to marry the man involved in the pregnancy.

Thirty-eight percent of Catholics, compared with 34 percent of Protestants, approve of abortion for any reason; and the average proportions in each group who approve for all reasons combined are virtually the same—52 percent of Catholics, compared with 51 percent of Protestants. Strength of religious commitment makes a much more substantial difference, whatever the religious affiliation. Thus, the most committed have an average approval rate of 49 percent for all reasons combined, and the least committed, one of 68 percent. An even larger gap exists between respondents who have had less than a high school education and those who have attended college—47 percent of the former approve of legal abortion, compared with 72 percent of the latter. Approval averages 61 percent among whites, 49 percent among blacks. The differences in the average levels of approval reported by men and women, and by people younger than 30 and older than 65, are small (63 percent vs. 57 percent, and 60 percent vs. 54 percent, respectively). Democrats and Republicans are equally likely to express approval (59 percent and 60 percent, respectively).

Table 1. Percentage of U.S. adults approving of legal abortion for various reasons,* NORC General Social Surveys, various years

Reason	1987	1985	1972	Avg., 1972–1987
Serious health endangerment	88	89	87	90
Strong chance of serious defect	80	79	79	82
Pregnancy the result of rape	81	81	79	83
Low-income, can't afford	45	44	49	50
Unmarried, doesn't want to marry man	42	41	44	46
Married, wants no more children	42	40	40	44
Any reason	40	37	38	38†
Avg., all reasons	63	62	59	66

*Nonresponses distributed proportionally.
†1977–1987

Reference

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Washington Memo

A Publication of
The Alan Guttmacher Institute
November 13, 1986 (W-17)

The 1986 Elections, Part I. . .

Election Day Ends in Defeat for All State Antiabortion Referenda

In a result that surprised political observers as well as activists on both sides of the issue, all four of the antiabortion ballot measures up for consideration this past election day were rejected by the voters. If they had been approved, these proposed state constitutional amendments would have restricted state-financed abortion services, and three of them would have set the stage for states to outlaw abortion if the U.S. Supreme Court were to overturn its *Roe v. Wade* decision. Three of the referenda, in Massachusetts, Oregon and Rhode Island, were defeated by impressively large margins. In Arkansas, the result was a cliffhanger with the winning margin consisting of only a few hundred votes.

Placing antiabortion referenda on statewide ballots has become an increasingly popular strategy among right-to-life organizations, which are impatiently hoping for a reversal of the *Roe* decision or a congressional antiabortion amendment to the U.S. Constitution. Recognizing that it is easier to change state constitutions than the federal one, these groups have set out to establish state abortion policies that are as restrictive as possible. Since 1978, 17 measures, including the four this year, have been proposed in 11 states (and this does not include nonbinding referenda, such as those voted down in Connecticut and New Hampshire last year). Measures in California, Montana and Washington were proposed for inclusion on ballots this year, but they failed to garner enough signatures to qualify (see *Washington Memo*, W-14, September 17, 1986). So far, then, 12 statewide antiabortion measures have been voted on in the last eight years and only one, in Colorado, has been adopted. (The Colorado measure was approved in 1984 by a 50.4 percent margin and was implemented by the legislature in 1985 to prohibit the use of public funds for abortion except in cases of life or mental health endangerment or fetal defect.)

State funding for abortion is the focal point of these referenda because, even though the U.S. Supreme Court has ruled that neither the states nor the federal government are required by the *federal* Constitution to fund abortions not necessary to save the woman's life, high courts in several states (California, Connecticut, Massachusetts, New Jersey and Vermont) have interpreted their own constitutions as affording greater protections for individuals seeking abortions than the federal Constitution. Moreover, nine other states and the District of Columbia have chosen to voluntarily continue state funding for medically necessary abortions. Significantly, however, anti-funding referenda also are being proposed in states that do not fund abortions, apparently as a "hedge" against any future state decision to do so.

Three of the referenda voted on this past election day would have prohibited state funds for abortion, except when necessary to prevent the death of the pregnant woman, and Rhode Island's would have barred funding in all cases. The right-to-life organizations that sponsored these measures portrayed them not only as declarations on the morality of abortion, but as practical financial measures aimed at saving taxpayer money. However, a recently published Alan Guttmacher Institute (AGI) study demonstrates that taxpayer money is not saved when abortion services are denied (see *Washington Memo*, W-10, June 30, 1986). The AGI state-by-state study compares the cost of subsidizing abortions for indigent women with the cost of providing medical and welfare services to those indigent women who would be forced to carry their pregnancies to term because of the denial of subsidized abortions. The study shows that, nationwide, at least four tax dollars will be spent for every dollar saved by refusing to fund abortions for Medicaid-eligible women.

The most straightforward of the proposed antiabortion measures was the one in Oregon, which dealt with the funding issue only. Voters defeated it by 54.5 percent to 45.5 percent, a wider margin than had been predicted. In 1978, Oregon was the first state to vote on an antiabortion initiative, which also was rejected, although by a considerably narrower margin. Moreover, that initiative did

not even include an exception for life-threatening cases. Oregon voluntarily funds abortions for poor women; its legislature has never voted to prohibit funding. Also, a court of appeals decision held in 1983 that an Oregon law limiting women to two Medicaid abortions violated the state's constitution.

In Massachusetts, meanwhile, a proposed antiabortion constitutional amendment was overwhelmingly rejected, by a margin of 58 percent to 42 percent. Approval of the measure would have empowered the legislature to regulate abortion to the maximum extent permitted under the federal Constitution without regard to other *state* constitutional safeguards of individual rights. The referendum's immediate effect would have been to eliminate public funding for abortion. Massachusetts has been paying for medically necessary abortions ever since the state's highest court held that a law that prohibited Medicaid funding except in cases of life endangerment violated the state constitution's due process clause. If the measure had passed, that ruling would have been overturned and the funding issue would have been returned to the legislature, which almost certainly would have voted to prohibit reimbursement for virtually all abortions. And, if *Roe* were overturned, the legislature could then prohibit all abortions in the state.

The proposed measures in Rhode Island and Arkansas were similar to the one in Massachusetts in that they, too, could have made abortion illegal with a reversal of *Roe*, but they also went a step further by establishing special constitutional protections for fetuses. Neither state currently provides funds for abortions for poor women. The vote in Rhode Island — the nation's most heavily Catholic state — was stunning; the proposed antiabortion constitutional amendment was defeated by 65.3 percent to 34.7 percent.

In Arkansas, on the other hand, the result was a squeaker. The Arkansas measure would have protected every "unborn child from conception until birth" and would have allowed funding only in cases of life endangerment. Voters rejected the initiative by an extremely close margin of only a few hundred votes. This, however, despite the fact that antiabortion activists had predicted an easy win.

Thus, 1986 provided a clean sweep for the prochoice position at the state level. In addition to the antiabortion measures that were defeated in Arkansas, Massachusetts, Oregon and Rhode Island, Connecticut voters also rejected a call for a state constitutional convention. The vote was a decisive 64 percent to 36 percent, with opposition from prochoice groups focusing on the opportunity passage would offer to those anxious to make changes to the state's constitution, like the ones proposed for its sister states, Massachusetts and Rhode Island.

Abortion Training in U.S. Obstetrics And Gynecology Residency Programs

By Philip D. Darney, Uta Landy, Sara MacPherson and Richard L. Sweet

Summary

The majority (72 percent) of U.S. residency programs in obstetrics and gynecology include first-trimester abortion techniques in their training. Programs affiliated with public hospitals or with private non-Catholic institutions are the most likely to provide such training, while Catholic-affiliated training programs and those at military hospitals are the least likely to do so. Approximately 23 percent of institutions include abortion training as a routine part of residency, and 50 percent offer it as optional training. The 28 percent of residency programs that offer no abortion training represents an almost fourfold increase since 1976. Although more of the large programs affiliated with public hospitals now include such training as a routine part of their residency programs, fewer of the private non-Catholic programs—where the largest proportion of residents are trained—do so. Consequently, the number of residents exposed to abortion training may have declined slightly over the past decade. Little difference exists between the proportion of programs that offer training in first-trimester techniques and the proportion that train in second-trimester techniques.

Nine percent of programs report that all residents participate in first-trimester abortion training, and another 56 percent report that at least half of their residents do so. The participation rate is linked to the expectations of the program: Approximately 88 percent of programs that routinely incorporate abortion techniques in their training report that from one-half to all of their residents participate, compared with about 55 percent of programs that offer the training as an option.

Approximately 82 percent of programs teach abortion techniques up to at least 20 weeks' gestation. However, in only 10 percent of programs do residents collectively perform more than 10 abortions per week.

Introduction

After the legalization of abortion in 1973, the number of procedures performed annually in the United States increased rapidly, subsequently leveling off at about 1.6 million.[1] The morbidity and mortality experiences of women undergoing induced abortions, most of which are performed by obstetrician-gynecologists,[2] suggest that these surgical procedures are safe and represent little risk to women's health.[3]

What role have obstetrics and gynecology residency programs played in providing future practitioners with adequate training in abortion? A survey carried out shortly after the legalization of abortion found that "many university departments have not fully assimilated the elective abortion as an integral part of the service and educational responsibility of obstetrics and gynecology. The pressing demand for abortion services will require many obstetricians and gynecologists to be prepared."[4] A second survey of residency training programs in obstetrics and gynecology, conducted five years later, noted little improvement in the situation: Between 20 and 40 percent "of all residents are estimated to have had no clinical experience in performing first-trimester abortions," the study stated, concluding that "a substantial minority of teaching hospitals provided so few abortions that they could not possibly offer adequate training in this area."[5]

Approximately 10 years have passed since the last survey of residency training in elective abortion was conducted. During that time, more than 10 million American women have terminated pregnancies. Have the passage of time and the further acceptance of abortion as a needed medical service improved the proportion of residency programs that provide training in the performance of first- and second-trimester abortions? We present the results of a third survey on the status of abortion training in U.S. obstetrics and gynecology residency programs.

Methodology

In July 1985, we mailed a two-page questionnaire to the directors of all 286 residency programs listed by the Council on Resident Education in Obstetrics and Gynecology. In November 1985, a second mailing of the same questionnaire went to all directors who failed to respond to the first letter. To obtain responses comparable to those from previous surveys, we modeled the questionnaire after the one used in 1976.*

The questionnaire asked the director of the program or the individual responsible for abortion training to provide information on the proportion of residents who receive training in first- and second-trimester elective abortion, the proportion who

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*Both surveys covered all obstetrics and gynecology residency programs. However, the 1976 questionnaire went to directors at each teaching hospital, while the 1985 questionnaire went to directors of programs, many of which cover several teaching hospitals. Consequently, there were 438 possible respondents to the 1976 questionnaire and 286 possible respondents to the 1985 questionnaire. Nonetheless, the 1986 survey actually covered more residency positions than did the earlier survey—4,506 compared with 4,011.

decline to participate and the reasons for that decision, the role of attending physicians in supervision and training, the location of the training and the methods of abortion taught. In addition, respondents were asked for information on the type of hospital, the number of abortions provided, the duration of residency training in abortion, the number of residents in the program and whether residents perform abortions outside of the program. Directors could respond anonymously, if they wished, and their general opinions about abortion training for residents were solicited. Responses were tabulated by geographical region and by the affiliation of the principal teaching hospital—public, private (non-Catholic and Catholic) and military.

Table 1 compares the number and percentage distributions of all obstetrics and gynecology training programs and of residency positions in the United States with the distributions of those that responded to the survey. Overall, 87 percent of residency training programs, representing 90 percent of all residency positions, returned the questionnaire. This response rate is considerably higher than the rates achieved in the earlier studies, and accurately reflects the geographical distribution of both obstetric and gynecology training programs and residency positions in the United States.

All of the training programs in the New England, Mountain and Pacific regions returned the questionnaires. The East South Central region had the lowest response rate, returning just over half of its surveys. This region, which encompasses the states of Alabama, Kentucky, Mississippi and Tennessee, has had a decrease of 10 percent in the number of abortions performed since 1982, while the number of abortions performed nationally has risen slightly.[6] In addition, 16 percent of women from this region who obtained abortions in 1981 did so outside of their home state, compared with only six percent nationally. These figures, and the low response rate to the survey, indicate that interest in providing abortion services and training may be less in the East South Central Region than in other regions of the country, although we did not examine the data by region.

Response rates were highest from public institutions (96 percent) and lowest from private non-Catholic institutions (79 percent). However, the institutions responding from the latter category had large teaching programs that represented 90 percent of all residency positions in private non-Catholic hospitals. Training programs at Catholic and military hospitals together represent only 21 percent of all programs and 16 percent of residency positions. The response rates for these two types of programs were not markedly different from those of other institutions.

Table 1. Number and percentage distribution of all training programs in obstetrics and gynecology and of residency positions in those programs; number and percentage distribution of programs and residency positions responding to abortion survey; and response rate; by region and by hospital affiliation, United States, 1985

Region and affiliation	Training programs					Residency positions				
	Total		Responses		Response rate	Total		Responses		Response rate
	N	%	N	%		N	%	N	%	
Total	**286**	**100.0**	**248**	**100.0**	**86.7**	**4,506**	**100.0**	**4,072**	**100.0**	**90.4**
Region*										
New England	18	6.3	18	7.3	100.0	270	6.0	270	6.6	100.0
Middle Atlantic	67	23.4	58	23.4	86.6	989	21.9	989	24.3	100.0
South Atlantic	50	17.5	46	18.5	92.0	797	17.7	739	18.1	92.7
East North Central	56	19.6	46	18.5	82.1	815	18.1	689	16.9	84.5
West North Central	16	5.6	12	4.8	75.0	255	5.7	227	5.6	89.0
East South Central	12	4.2	7	2.8	58.3	226	5.0	115	2.8	50.9
West South Central	25	8.7	19	7.7	76.0	463	10.3	352	8.6	76.0
Mountain	10	3.5	10	4.0	100.0	154	3.4	154	3.8	100.0
Pacific	32	11.2	32	12.9	100.0	537	11.9	537	13.2	100.0
Affiliation										
Public	96	33.6	92	37.1	95.8	1,746	38.8	1,561	38.3	89.4
Private										
Non-Catholic	131	45.8	103	41.6	78.6	2,052	45.5	1,855	45.6	90.4
Catholic	45	15.7	41	16.5	91.1	504	11.2	472	11.6	93.7
Military	14	4.9	12	4.8	85.7	204	4.5	184	4.5	90.2

*New England: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont; Middle Atlantic: New Jersey, New York and Pennsylvania; South Atlantic: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia and West Virginia; East North Central: Illinois, Indiana, Michigan, Ohio and Wisconsin; West North Central: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota and South Dakota; East South Central: Alabama, Kentucky, Mississippi and Tennessee; West South Central: Arkansas, Louisiana, Oklahoma and Texas; Mountain: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah and Wyoming; Pacific: Alaska, California, Hawaii, Oregon and Washington.

Note: Surveys that were answered anonymously were assigned to geographic regions according to the proportions of respondents within these regions. As the Middle Atlantic region had a disproportionate number of responses from large residency programs, it was allotted more residency positions than programs from the anonymous responses. Consequently, this region shows a 100 percent response rate for residency positions but only an 87 percent response rate for programs.

Training Opportunities

Overall, 72 percent of institutions responding to the 1985 survey reported that they include first-trimester abortion training in their residency programs. These programs train about 75 percent of all residents in obstetrics and gynecology. Table 2 (page 160) shows that 23 percent of programs incorporate abortion training as a routine part of residency (with exceptions for residents who have religious and moral objections) and 50 percent offer it as an option. Teaching programs affiliated with public hospitals are the most likely to provide their residents with the opportunity to be trained in abortion techniques (87 percent), followed closely by private non-Catholic programs (84 percent). About one-third of institutions in these two categories that provide first-trimester abortion training include it routinely in their programs; the remainder offer it as an option. Among Catholic-affiliated institutions, 27 percent provide such training, and less than one-fifth of these include it routinely. Military programs, which are restricted by federal law from performing abortions except to save the life of the mother, have the lowest proportion of respondents saying that they give residents the opportunity to learn to perform abortions: None routinely provide such training and only 17 percent offer it on an optional basis.

Training in second-trimester abortion techniques is provided only slightly less frequently than is training in first-trimester techniques. Overall, 65 percent of programs offer their residents training in second-trimester techniques, and one-third of these make it a routine part of training.

Table 2 shows that 28 percent of obstetrics and gynecology training programs in the current survey do not teach residents how to do abortions, a situation that was characteristic of only eight percent of training programs in 1976. In addition, a slightly

smaller proportion of programs in 1985 than in 1976 include abortion training as a routine part of residency—23 percent and 26 percent, respectively. However, there has been a large increase in the proportion of public hospital residency programs that routinely include training in first-trimester abortion techniques—28 percent in 1985 compared with 19 percent in 1976.

The situation is much the same with regard to second-trimester abortion training. In 1976, only 16 percent of hospital teaching programs omitted such training, but by 1985, 36 percent did so. However, a larger proportion of public institutions now routinely expect their residents to complete training in second-trimester abortion—26 percent in 1985 compared with 16 percent in 1976.

Although public hospitals report an increased number of programs that routinely incorporate training for first- and second-trimester abortion, the number of public hospitals providing either routine or optional training has decreased in the past 10 years. One explanation for the decrease might be that fewer abortions are performed in hospitals—52 percent in 1973 but only 18 percent in 1982.[7] The proportion of abortions performed in freestanding clinics has steadily increased over the past decade, and now more than 80 percent are performed in such settings.[8]

Table 2. Percentage distribution of obstetrics and gynecology residency programs, by availability of abortion training and hospital affiliation, according to trimester, 1985 and 1976

Abortion training and affiliation	1st trimester		2nd trimester	
	1985	1976	1985	1976
Routine	**22.6**	**26.3**	**20.6**	**22.5**
Public	28.3	18.8	26.1	16.2
Private				
Non-Catholic	27.2	36.3	25.2	31.0
Catholic	4.9	0.0	2.4	0.0
Military	0.0	u	0.0	u
Optional	**49.6**	**66.2**	**44.0**	**61.5**
Public	58.7	76.2	52.2	72.5
Private				
Non-Catholic	56.3	63.7	48.5	58.4
Catholic	21.9	40.0	22.0	35.0
Military	16.7	u	16.7	u
None	**27.8**	**7.5**	**35.5**	**16.0**
Public	13.0	5.0	21.7	11.3
Private				
Non-Catholic	16.5	0.0	26.2	10.6
Catholic	73.2	60.0	75.6	65.0
Military	83.3	u	83.3	u
Total	100.0	100.0	100.0	100.0

Note: u=unavailable.

Source: Data for 1976 are derived from reference 5.

The increase in public programs that make abortion training a routine part of residency is counterbalanced by a decline among private non-Catholic programs. In addition, although all of these programs offered either routine or optional abortion training in 1976, 17 percent of them offered no training in 1985. Because these institutions account for the largest proportion of residency positions in obstetrics and gynecology, the number of residents in programs that offer abortion training probably declined slightly between 1976 and 1985 (for first-trimester abortion training, from approximately 3,700 to 3,250).

These findings also suggest that Catholic hospitals were less likely to provide abortion training in 1985 than in 1976. Military hospitals were the least likely to provide abortion training in 1985, but no earlier data on their programs are available for comparison.

Only nine percent of programs that provide abortion training reported that all of their residents participate in first-trimester abortion services (see Table 3). Another 56 percent of programs reported that at least half of residents participate, while two percent said that none of their residents did so. Eleven percent of the respondents that provide second-trimester abortion training said that all of their residents participate, another 53 percent reported that at least half do so, and one percent said that none participate (not shown).

Levels of resident participation in abortion training are linked to the program's expectations. Among programs that expect residents to train in abortion as a matter of course and make first-trimester abortion training a routine part of the program, 20 percent stated that all of their residents participate, and another 68 percent stated that at least half participate. Among programs that offer such training as an option, only four percent indicated that all residents participate, and another 51 percent said that at least half do so. The proportions are similar for programs routinely providing second-trimester abortion training compared with those offering optional training.

Private non-Catholic programs have the highest level of resident participation in training for both first- and second-trimester abortion. Ten percent of these institutions that provide training in first-trimester procedures said that all of their residents participate, and another 60 percent reported that more than half of residents participate. In addition, 14 percent of private non-Catholic institutions that offer second-trimester abortion training reported that all residents participate, and another 54 percent reported that more than half participate.

The lowest participation rates are found in the two military hospitals that offer abortion training: One institution reported that no residents participate in training, and the other reported a participation rate of fewer than one-half. Fifty-five percent of Catholic-affiliated teaching programs that offer first-trimester abortion training reported that fewer than half of their residents receive training, and 40 percent of those offering second-trimester training said that fewer than half of residents participate. Among programs that are affiliated with public hospitals and offer first-trimester training, 64 percent reported that half or all of their residents participate, and 61 percent of those that offer second-trimester training reported that half or all of residents receive this training.

Almost half (47 percent) of the respondents said that at least 90 percent of residents who do not participate in first-trimester abortion training decline to do so for religious or moral reasons. Only four percent of institutions reported that 10 percent or fewer of their residents reject abortion training for these reasons. For training in second-trimester techniques, 39 percent of respondents indicated that 90 percent or more of residents who do not receive training decline for religious and moral reasons, compared with six percent of respondents who said that fewer than 10 percent of residents reject training for these reasons. Programs in which relatively small proportions of residents do not participate in training have the highest proportions of nonparticipants citing religious or moral considerations, probably because these programs expect residents to participate unless they have such objections.

Abortion training is nearly always offered to residents in a hospital environment. Less than five percent of training in first-trimester abortion techniques and less than three percent of training in second-trimester procedures occur outside of a hospital. Among Catholic-affiliated teaching programs, however, 45 percent of institutions providing opportunities for first-trimester training make them available outside of the hospital setting.

Well over half of the respondents reported that an attending physician is always present while residents perform first-trimester abortions. One-third reported the presence of attendings either sometimes or most of the time, and fewer than one percent said that residents are never supervised by senior physicians. Catholic institu-

tions are the most likely to have an attending physician present at all times. A higher proportion of hospitals have attending physicians present during second-trimester procedures (68 percent, always; 30 percent, sometimes or most of the time), and the discrepancy between Catholic and non-Catholic institutions is less marked.

The majority of programs that include second-trimester abortion in their residency training provide abortion services up to 20 weeks' gestation (54 percent). An additional 28 percent provide services beyond 20 weeks. Five percent restrict services to 16 weeks or less, and 13 percent, to 17–19 weeks. There are no great differences by hospital affiliation.

Respondents from 70 percent of the teaching programs that provide training in second-trimester abortion reported that the methods that they teach include dilatation and surgical evacuation, prostaglandin infusion and prostaglandin with other agents. Only 40 percent mentioned saline infusion.

Twenty-five percent of respondents estimated that their residents collectively perform no more than one first-trimester abortion per week, and 65 percent said that their residents carry out 2–10 abortions per week, on average. Only 10 percent of institutions reported that residents collectively perform more than 10 abortions a week. Catholic and military programs are twice as likely as other institutions to report that residents perform less than one abortion weekly, while residents in public institutions are most likely to perform more than 20 first-trimester abortions a week.

Nearly two-thirds of respondents reported that their residents average no more than one second-trimester abortion a week. All of the Catholic programs gave this answer, and only one program out of the 160 that include second-trimester abortion training reported that residents collectively perform more than 10 second-trimester procedures a week.

Program directors were asked if their residents were permitted to "moonlight" during their off-hours to gain abortion experience outside of the program. The response was almost evenly divided, with 46 percent saying that residents are permitted to moonlight and 54 percent reporting that they are not. None of the residents in military programs are allowed to moonlight, and fewer than 30 percent of those in Catholic hospitals may do so. Nearly half of private programs and 60 percent of public programs indicated that their residents are allowed to perform abortions in their off-hours if they wish.

Respondents' Comments

In addition to answering specific questions, 161 respondents (65 percent) took the opportunity to comment on abortion training. While their remarks were varied, certain trends are apparent. Eighteen commented that they consider resident training in abortion an important part of residency in obstetrics and gynecology, but that current training is generally inadequate: "Unfortunately, too few see the technical value in learning the procedure well," commented one respondent. Seven directors—none of whose programs include abortion training—stated that abortion is an unacceptable practice and should not be taught to residents: "Our institution is philosophically opposed to abortion and [it] attempts to impart this philosophy to its residents," wrote one director.

Twenty-eight respondents noted that their abortion training programs are restricted by various governing bodies. The restrictions range from federal regulations to limits imposed by hospital boards of trustees. Of the 12 responding military hospitals, 11 mentioned federal restrictions on the performance of abortions, and four respondents expressed dissatisfaction with the restrictions. One respondent wrote, "This is a military facility and is prohibited by law from performing abortions except to save the mother's life. I believe this is deplorable, and both patients and residency training suffer because of this limitation."

Eighteen respondents stated that they thought attending lectures, reading and treating abortion complications—but not participating in actual procedures—was sufficient for residents in obstetrics and gynecology. Six of these 18 statements came from Catholic- and military-affiliated institutions that do not include abortion procedures in their training; the remainder came from programs that offer optional abortion training.

Eleven respondents said that they perceived a certain degree of apathy or a lack of initiative regarding abortion training on the part of residents in obstetrics and gynecology, and sometimes on the part of attending physicians as well. One director commented, "The abortion experience is suboptimal. Enthusiasm for abortion is lacking in both attendings and residents."

Thirteen program directors said that residents' exposure to abortion techniques is limited because most of the area's abortions are performed in freestanding clinics. Thirteen respondents remarked that abortion training is an integral part of the residency programs offered at their institutions and, as such, is not given any special attention. "We do not single [abortion] out as a special or specific item. It is just one of many procedures a resident learns. . . . Highlighting it gives it more exposure than it deserves," observed one survey respondent.

Table 3. Number of obstetrics and gynecology residency programs responding to survey that said they offer training in first-trimester abortion procedures, by estimated percentage of residents participating in abortion training, according to availability of training and hospital affiliation

Availability of training and hospital affiliation	All	% participating			
		0	1–49	51–99	100
Total	**179**	**3**	**59**	**101**	**16**
Availability					
Routine	56	0	7	38	11
Optional	123	3	52	63	5
Affiliation					
Public	80	2	27	44	7
Private					
Non-Catholic	86	0	25	52	9
Catholic	11	0	6	5	0
Military	2	1	1	0	0

Discussion

An important question to ask when assessing abortion training in U.S. residency programs is whether residents have access to such training in the first place. Although the majority of programs (72 percent) offer training, the proportion represents a 22 percent decline from the proportion 10 years ago. Nearly half of the programs allow residents to seek additional experience in their off-hours if they wish, but more than half do not. Among those programs that do not provide any opportunity for abortion training, the proportion that do not allow moonlighting rises to two-thirds. Thus, residents in 18 percent of programs (13 percent of all residents) appear to have no access whatsoever to abortion training. Abortion is the most common surgical procedure that women undergo, and it seems reasonable to expect a graduate of an obstetrics and gynecology training program to understand the procedure thoroughly, even if she or he will not personally perform the operation.

What can we conclude about the quality of abortion training received by residents in obstetrics and gynecology? Using as criteria the presence of attending physicians during abortion procedures, the variety of second-trimester methods taught and the gestational durations up to which abortions are performed, we believe that the structure of existing training programs is generally adequate. In 85 percent of pro-

grams, residents performing first-trimester abortions are supervised by attending physicians all or most of the time; this proportion is nearly 90 percent during second-trimester abortions. Nine out of ten programs that offer first-trimester training also offer second-trimester training. Nearly 85 percent of programs that teach residents to perform second-trimester abortions do so up to 20 weeks or more of gestation, and the same proportion of programs teach two or more methods of performing second-trimester abortions.

Any problems related to the quality of training seem to stem from the inadequate abortion caseloads found at most hospitals. Because only 13 percent of all abortions in 1985 were performed in hospitals,[9] residents may not acquire enough experience to become truly competent. Ten years ago, the failure of hospitals to provide abortion services was also seen as an element contributing to the inadequacy of abortion training,[10] and the hospitals' share of abortions has decreased even further since then. The finding that only a small proportion of respondents indicate that their residents collectively perform more than 10 abortions a week supports the conclusion that most hospital abortion caseloads are not sufficient for residency training purposes.

The authors of earlier studies on abortion training in the United States predicted that inadequate training could result in a lack of abortion services in the future.[11] However, between 1975 and 1985, progressively larger numbers of American women obtained elective abortions each year, resulting in an increase in the annual number performed of about 50 percent.[12] Yet the results of our survey show that the number of residents being trained to perform first- and second-trimester abortions may have declined during that same period. In addition, although most gynecologists believe that abortion services should be available to women, a much smaller proportion (34 percent) actually perform abortions themselves.[13]

These data support the premise that abortion, like many other medical services, has become increasingly specialized. Most abortions are performed in freestanding clinics that are planned, equipped and staffed especially for this purpose.[14] The clinics employ physicians who are skilled in abortion techniques and who perform the operations frequently. Among the approximately 70 percent of residents identified in this survey as having received some training in abortion, only a small proportion will perform the operation frequently. Where demand for the operation is sufficient, it appears that a relatively small number of interested, skilled individuals can provide high-quality services to a large number of women.

Any greater emphasis on, or greater availability of, abortion training in residency programs would, therefore, appear unlikely to have much effect on services in urban areas, where high-quality abortion services are already widely available. However, increased attention to this aspect of obstetrics and gynecology training might have an effect in nonurban areas, where demand is lower and where specialized abortion services are far less likely to be available. In nonmetropolitan areas, there is a greater dependency than in urban areas on physicians in hospitals and office practices to perform abortions.

There is good evidence to suggest that training makes a difference in the degree of safety with which gynecologists perform abortion,[15] but there is no guarantee that properly trained physicians will provide abortion services when they begin private practice. Political and religious attitudes toward abortion are generally more conservative in nonmetropolitan than in urban areas, and that may have as much to do with limited access to abortion in these areas as does inadequate training of physicians.

How can residency programs for obstetrician-gynecologists ensure adequate training in surgical procedures that are more and more commonly and efficiently performed outside of the hospital setting? (Because of changes in the health care system, advances in technology and pressure on hospitals to contain costs, this is a problem not only for abortion services but for any number of surgical and diagnostic procedures.) Our findings indicate that training opportunities for abortion are declining, and they will undoubtedly continue to do so, unless changes are made in hospital services and training settings. For example, hospitals that do not already have clinic-based abortion services could establish them.[16]

If, for political and economic reasons, hospitals continue to reduce abortion services, adequate opportunities for resident training must still be made available. One way to expand such opportunities would be to arrange rotations for residents in local abortion clinics. The clinics would provide specialist supervision and would pay a portion of the resident's salary. In return, the clinics would receive inexpensive physician services for their patients and would benefit from the prestige and intellectual stimulation associated with the affiliation with an academic institution. The teaching hospitals would benefit from adequate numbers of abortions to ensure proper training, from consistent and competent specialist supervision for their residents and from the savings on residents' salaries.

Teaching hospitals are unlikely to provide adequate training for future obstetrics and gynecology residents if they continue to rely on traditional approaches. Moreover, a thoughtful and innovative response to the improvement of abortion training could provide the framework for ensuring that residents will be adequately trained in other outpatient procedures as well.

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DIGEST

Well-Trained Physician Assistants Can Perform Early Abortions Safely

Well-trained physician assistants are found to perform first-trimester abortions as safely as physicians, when outcomes are measured in terms of complication rates. A two-year prospective study conducted at the Vermont Women's Health Center revealed no significant differences in overall, immediate or delayed complication rates between women whose first-trimester abortions were performed by physician assistants and those whose abortions were performed by physicians.[1] Although a number of studies have shown that physicians can provide first-trimester abortions safely in an outpatient setting, this study represents the first evaluation of the performance of physician assistants relative to the results achieved by medical practitioners.

The study sample consisted of all women who obtained a first-trimester abortion at the Vermont Women's Health Center between January 1, 1981, and December 31, 1982. During that period, a total of 2,458 pregnancy terminations were included in the study: 1,285 were performed by physician assistants and 1,173, by physicians. There was no differential allocation of patients to physicians or to physician assistants: Patients were seen by whichever provider was available in the clinic. In general, the study group was representative of the population of women seeking abortions in Vermont. The majority were white (98 percent), single (77 percent) and under 25 years of age (71 percent). Fifty-four percent were pregnant for the first time, and 68 percent had had no previous abortions.

The clinic used only two abortion methods, both under local anesthesia: early uterine evacuation and suction curettage. Clinic protocol required that early uterine evacuation be performed no later than eight weeks following the patient's last menstrual period, provided this criterion was consistent with uterine size as determined by pelvic examination.

Patient participation in the study was voluntary. At discharge from the center, women were instructed to return to the clinic for a checkup or to see their own doctor within four weeks. Those who elected to see their personal physician were given a questionnaire dealing with possible delayed complications, to be filled out by the private physician and returned to the clinic for analysis. Immediate complications were defined as those evident before discharge; delayed, as those noted any time within the four-week postabortion period.

The overall complication rate associated with abortions performed by physician assistants was 27 per 1,000 procedures, compared with a rate of 31 per 1,000 following those carried out by doctors. The immediate complication rates were five per 1,000 procedures performed by physician assistants and eight per 1,000 in the comparison group. Delayed complication rates were 23 and 24 per 1,000 abortions for physician assistants and for physicians, respectively. The researchers attribute the fact that the delayed complication rate was over twice that reported in a previous study to the aggressive follow-up that was carried out in the Women's Health Center study.

Type of abortion procedure was the only variable that significantly affected the total complication rate. The authors found a higher total complication rate associated with abortions performed by early uterine evacuation (39 per 1,000 procedures) than with those carried out by suction curettage (23 per 1,000). They further discovered that the total complication rate among women who had an early uterine evacuation at 7–8 weeks' gestation (49 per 1,000) was substantially higher than the rate among those whose abortions were performed at less than seven weeks' gestation (five per 1,000). (In response to this finding, according to the investigators, the center altered its protocols for uterine evacuation procedures.) Early uterine evacuation was associated with an increased number of delayed complications such as uterine hemorrhage and retained products of conception, and this relationship was independent of practitioner category.

Physician assistants have been providing pregnancy terminations in Vermont since 1975. They perform more than 20 percent of the 3,500 abortions that are done yearly in the state. The absence of differential complication rates following abortions performed by physicians and those performed by physician assistants could have significant implications for the future involvement of physician assistants in the provision of abortions, according to the authors. However, they caution that because of the clinic's rigorous apprenticeship system for trainee assistants and the unique homogeneity of the population served at the Vermont Women's Health Center, it may be inappropriate to generalize their conclusions to other abortion programs.

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Induced Abortion and Fertility

By Tomas Frejka

Summary

Even in countries with high rates of legal induced abortion, contraceptive use and marital patterns nearly always have a greater impact on fertility levels than does abortion. As a rule, extremely high rates of abortion—three or more abortions per woman of childbearing age during the reproductive years—are required for the fertility-inhibiting effect of abortion to rival that of contraceptive use. Nevertheless, the absolute effect of abortion on fertility (defined as the amount by which the current total fertility rate, or TFR, would increase if no abortions were performed) is often substantial. In most of the countries examined, the TFR would have been from about 20 percent to nearly 90 percent higher than it actually was (other things being equal) had no induced abortions been performed.

Among developed countries, the Soviet Union, Japan, Eastern European countries, Israel and the United States have the highest total legal abortion rates, ranging from one abortion to more than five abortions per woman of childbearing age during the reproductive years. Among the developing countries for which reliable data are available, South Korea, China, Cuba and Singapore have rates of about 1–2 abortions per woman of fertile age. However, a number of other countries in Latin America and Asia, for which the data are deficient, probably have equally high rates.

Incidence of Induced Abortion

Legal or illegal induced abortion is performed in nearly all the countries of the world,[1] and is recognized as an important determinant of fertility levels. About 10 percent of the world's population live in countries where abortion is prohibited, but more than 60 percent live in countries that permit the procedure on broad socioeconomic grounds or on request.[2] Information on the incidence of induced abortion is reasonably good for many of the countries that have enacted liberal abortion legislation. Where the procedure is illegal or restricted, however, the quality of abortion estimates made from indirect sources is highly variable, and often it is impossible to assess even approximately the actual incidence. Moreover, the quality of abortion data for a population, like the level of abortion itself, depends not only on the legal status of the procedure, but also on the way in which laws and policies are interpreted and enforced.

In this article, we attempt to provide a global picture of the incidence of induced abortion, as well as analyze its relative and absolute effects on fertility in those countries for which appropriate and reasonably reliable data are available. These data are generally missing for developing nations. For the most part, therefore, the analysis focuses on developed countries. The measure of abortion incidence employed here is the total abortion rate, or the average number of abortions a woman would have during her lifetime if age-specific abortion rates were to continue. To estimate the demographic impact of abortion, we have used the model developed by John Bongaarts for analyzing the fertility-reducing effects of the four major determinants of fertility: marriage, contraception, abortion and postpartum infecundability.[3]

The total abortion rate is calculated either by summing age-specific abortion rates or by multiplying the number of abortions per woman aged 15–44 by 30 (the number of years between ages 15 and 44). We have followed the latter procedure because those data are more widely available than are age-specific abortion rates. Table 1 presents total legal abortion rates over three decades for 23 developed and six developing countries. As the table shows, the Soviet Union, most of the countries of Eastern Europe, Japan, the United States and Israel have high rates of legal abortion (one or more per woman of childbearing age), as do China, Cuba, Singapore and South Korea. Moderate levels of abortion prevail in most of the industrialized countries of Western Europe.

The highest total abortion rates—five or more per woman—have historically been found in the Soviet Union. Levels of abortion in Eastern Europe have been high since the mid-1950s, when abortion legislation in the region was liberalized. Rates as high as those of the Soviet Union were recorded in Romania from the late 1950s until 1966; in that year, the legal grounds for abortion were sharply curtailed in response to concerns about falling birthrates. Nevertheless, in 1979, Romanian women of reproductive age were still obtaining 2.6 abortions each. Outside of Eastern Europe, Japan has had the highest total abortion rates since the late 1940s (2.5–4.1).

Of the other Asian countries for which data are available, China and South Korea have the highest total abortion rates. In China, the incidence of abortion has increased considerably since the late 1970s, amounting to 1.6 abortions per woman of fertile age in 1982; in South Korea, the incidence of legal abortion nearly doubled over the 10-year period 1965–1975, from 1.1 to 1.9 per woman. Though the data are fragmentary, there is also some evidence of extensive use of abortion in Indonesia and the Philippines,[4] both of which prohibit abortion, and in Thailand; for Thai women in the late 1970s, the total abortion rate may have exceeded one procedure per woman (not shown).[5]

The only reasonably reliable data on the incidence of abortion in Latin America come from Cuba, where the total abortion rate fluctuated between 1.2 and 2.1 during the 1970s and early 1980s. Though of doubtful quality, estimates for other Latin American

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countries (not shown) do suggest widespread utilization of abortion. For example, Chile in the 1960s had a total abortion rate of 2.5, and Colombia, a rate of 1.2. During the 1970s, Chile's rate reached 1.6; Mexico's, 1.5; Peru's, 1.3; and Brazil's, 0.5–1.5.[6]

Impact of Induced Abortion on Fertility

To measure the demographic impact of abortion, we use the model developed by John Bongaarts for estimating the relative importance of the proximate determinants of fertility—that is, the variables through which social and economic factors must operate to influence fertility. According to Bongaarts, four proximate determinants are primarily responsible for the level of fertility in a population: marriage, contraception, abortion and infecundability following childbirth.[7] These four variables shape fertility by reducing the total fecundity rate, which represents total potential fertility and is assumed to equal 15.3 births per woman. The relationship is expressed as follows:

$$TFR = C_m \times C_c \times C_a \times C_i \times TF$$

where TFR, the total fertility rate, represents actual fertility, TF is the total fecundity rate, and the remaining terms are indices constructed to measure the fertility-reducing effects of each of the proximate determinants (C_m, marriage; C_c, contraception; C_a, abortion; and C_i, infecundability). The indices each range in value from 0 to 1. A value of 0 indicates that the variable has a complete fertility-inhibiting effect, and a value of 1, that it has no such effect. Thus, the lower the value of any index, the larger the fertility-reducing impact. The amount of reduction attributable to the variable is indicated by the complement of the index. For instance, if as a result of marital patterns in a population, women spend, on average, only two-thirds of their reproductive lives exposed to the risk of conception, then C_m would be 0.67, signifying that the effect of marriage is to reduce fertility by 33 percent.

The determinants of each index are as follows:

- C_m. Two factors determine the value of the index of marriage—the average length of time that women spend in a sexual union (consensual as well as marital), thereby being exposed to the risk of conception; and the stage of the life cycle during which they live in union. Fairly early marriage, large proportions married and low incidence of divorce and widowhood will generate C_m values of about 0.8. Late marriage, small proportions married and, possibly, high divorce rates will generate values of 0.5–0.7.
- C_c. The index of contraception is based on the prevalence of contraceptive practice among women in stable sexual unions, and on the mix of contraceptive methods. If only a small proportion of the population practice contraception, and couples use ineffective methods, the value of the index can approach 1.0. For populations characterized by extensive contraceptive practice and widespread use of modern methods (sterilization, pill, IUD), the index will frequently be as low as 0.2.
- C_a. The major determinant of the index of abortion is the rate of induced abortion. The higher the rate, the lower the index. Several other factors, however, affect the index in important ways. First, considerably more than one abortion is needed to prevent one birth, because a pregnancy terminated by an abortion occupies a shorter period of the reproductive span than does a full-term pregnancy and subsequent infecundability. Second, intensive contraceptive practice enhances the birth-preventing effect of each abortion by diminishing the probability of conception; however, even when contraceptive use is widespread and highly effective, more than one abortion is needed to prevent one birth. Third, the Bongaarts model incorporates only abortions obtained by women in stable sexual unions. In populations where a substantial proportion of abortions

Table 1. Total legal abortion rates for selected countries, selected years, 1950–1980

Country	1950 or year as shown	1960 or year as shown	1970 or year as shown	1980 or year as shown
Eastern Europe				
Bulgaria	0.02 (1953)	0.9	1.9	2.1 (1979)
Czechoslovakia	0.03 (1954)	1.0	1.0	0.9
German Dem. Rep.	0.2	0.01	1.0 (1972)	0.7 (1977)
Hungary	0.02	2.3	2.5	1.1
Poland*	u	0.7 (1965)	0.6	0.5 (1978)
Romania	u	5.6	1.9	2.6 (1979)
Soviet Union	u	5.1	5.4	u
		6.6 (1965)		
		7.2 (1967)		
Yugoslavia	u	u	1.6	2.1 (1977)
Western Europe				
England and Wales	u	0.1 (1968)	0.2	0.4
France*	u	u	0.4 (1976)	0.5
Germany, Fed. Rep. of*	0.02	0.01 (1968)	0.01	0.3
Italy*	u	u	u	0.6
Netherlands	u	u	0.2 (1973)	0.2
Denmark	0.2 (1954)	0.1	0.3	0.6
Finland	0.1 (1951)	0.2 (1961)	0.4	0.4
Norway	u	0.1 (1964)	0.3	0.5
Sweden	0.1 (1954)	0.06	0.3	0.6
Outside Europe				
Australia	u	u	u	0.4
Canada	u	u	0.1	0.3
Israel	u	u	u	0.9 (1982)
Japan	4.0 (1955)	4.1	3.1	2.5 (1975)
New Zealand	u	u	0.2 (1976)	0.3
United States	u	0.004 (1963)	0.5 (1973)	0.9
China, People's Rep. of	u	u	0.7 (1971)	1.6 (1982)
Cuba	u	0.5 (1968)	1.2	1.6 (1982)
India*	u	u	0.01 (1973)	0.1
Korea, Rep. of	u	1.1 (1965)	1.5	1.9 (1975)
Singapore*	u	u	0.1	0.9
Tunisia*	u	0.05 (1966)	0.1	0.5

*Reporting incomplete. Note: u = unavailable.

Sources: China—J. Banister, *China's Changing Population*, Stanford University Press, Stanford, Calif., 1985 (forthcoming); Israel—E. F. Sabatello, "Estimated Abortion and Fertility in Israel: An Application of the Bongaarts Model," paper presented at the annual meeting of the Population Association of America, Boston, Mar. 28–30, 1985; Korea—J. Bongaarts, 1982 (see reference 3); and E. H. Choi, P. J. Donaldson and D. J. Nichols, "Abortion and Contraception in the Korean Fertility Transition," *Journal of Population and Health Studies*, Vol. 2, No. 1, 1982; all other countries—C. Tietze, 1983 (see reference 1); see also C. Tietze, *Induced Abortion: 1979*, third ed., The Population Council, New York, 1979, and C. Tietze and M. C. Murstein, "Induced Abortion: 1975 Factbook," *Reports on Population/Family Planning*, No. 14, 1975.

are obtained by unmarried women (e.g., in the United States and Western Europe), the index of abortion underestimates the real effect of induced abortion on fertility.

• C_i. The primary determinant of postpartum infecundability is the duration of breastfeeding. For populations with long periods of breastfeeding (for example, 1–2 years), the index may have a value as low as 0.6; in modern populations with limited breastfeeding, it measures 0.9–1.0.

Columns 3–7 of Table 2 present the results of applying the Bongaarts model to data for nine developed and two developing countries. Total abortion rates are also included (column 2), to illustrate the range of fertility-inhibiting effects associated with varying levels of abortion utilization. In nearly all the countries, as the table shows, contraceptive use is the most important fertility-modifying factor, and marital patterns, the second most important. The fertility-inhibiting effect of abortion, usually third in importance in Eastern Europe, rises to second place only when the total abortion rate equals two or more. In any case, in all the Eastern European countries, the impact of abortion on fertility is substantially smaller than that of contraceptive practice. Even in 1966 in Hungary, when the level of abortion was high and the efficacy of contraceptive practice was relatively low (consisting mostly of withdrawal and condom use[8]), the effect of abortion was still four-fifths that of contraceptive use—that is, a 47 percent reduction in fertility compared with a 59 percent reduction, respectively. (The substantially higher abortion index for Hungary in 1977 reflects several changes occurring in the early 1970s: enactment in 1973 of restrictions on access to induced abortion, which may have accelerated an ongoing decline in the incidence of abortion; reinforcement of pronatalist social and economic measures; and a rapid increase in access to and use of modern contraceptives.)

Among the countries of Eastern Europe, Romania appears to be the exception to the rule (not shown). For almost a decade (1958–1966), the fertility-reducing effect of abortion in Romania was larger than that of any other proximate determinant. This conclusion is suggested by Romania's total abortion rate during those years, which was 1.5–2.8 times higher than the peak rate in Hungary (2.7 in 1969),[9] and by rough calculations of the indices. Application of the model to incomplete data for 1966 yields an index of abortion equal to 0.3, an index of contraception of 0.5–0.6, an index of marriage of 0.7, and an infecundability index of 0.9. Thus, the fertility-reducing effect of abortion was about double that of either contraception or marriage. Similar relationships probably prevailed during the 1950s and 1960s in the Soviet Union and, to a lesser extent, in Japan, where total abortion rates were also very high.

In Denmark, Finland and the United States, which had moderate abortion rates in the early 1970s, the impact of abortion on fertility was even smaller than in the Eastern European countries. Prior to nationwide legalization of the procedure in the United States in 1973, legal abortion had no effect on fertility, as the data for 1965 indicate; as the incidence of legal abortion increased during the 1970s, its fertility-reducing effect also increased. In Israel in 1982, where women obtained about one abortion each over their reproductive lives, marital patterns and contraceptive use had substantial and nearly identical effects on fertility (reductions of 55–66 percent); abortion use lowered fertility by somewhat less than 20 percent.

Fertility in Cuba and South Korea at the beginning of the 1970s was influenced more by contraceptive practice than by abortion, but the effect of abortion was not unimportant (about a 20 percent reduction). Cuba in 1972 was in the midst of its fertility decline. The data for Korea are interesting because they illustrate the relative impact of the proximate determinants in a developing country experiencing the initial stage of fertility decline: In 1960, the effect of abortion, like that of contraception, was negligible; the greatest impact came from postpartum infecundability, which reduced fertility by 44 percent. Between 1960 and 1970, a period of declining fertility, the effects of marriage, contraception and abortion increased, while that of postpartum infecundability decreased. However, in 1970, even though the total abortion rate was high, abortion had less of an impact on fertility than did any of the other three variables (18 percent vs. 23–42 percent).

Only exceptionally, then, has induced abortion been the primary means of fertility control used by a population. In nearly all the countries studied—even those with high levels of abortion—contraceptive practice and marital patterns have been the proximate determinants with the largest fertility-reducing effects. As a rule, only very high levels of abortion—an average of three or more procedures per woman over her lifetime—will imply a larger fertility-inhibiting effect than that attributable to contraceptive use.

Absolute Impact on Fertility

An issue of considerable interest is the absolute effect of abortion on fertility—that is, the amount by which the TFR of a population would increase, other things being equal, if no induced abortions occurred. While the absolute effect of abortion is directly related to the incidence of induced abortion in the population, the relationship is complicated by the fact that more than one abortion is required to avert one birth, even though just one abortion is required to terminate one pregnancy. The main reasons are that the gestational period preceding an abortion is shorter than that preceding a birth (three months, as opposed to nine months); and postgestational infecundability following an abortion is also shorter. Consequently, an abortion involves a much shorter duration of nonexposure to the risk of conception than does a full-term pregnancy. The number of abortions that avert one birth, moreover, varies greatly across populations. In populations where contraceptive use is widespread and breastfeeding is limited, slightly more than one abortion will avert one birth, whereas in populations with little contraceptive use and long periods of breastfeeding, 2–3 abortions must occur to avert one birth. Since the procedure for calculating the index of abortion (C_a) takes into account the shorter gestation represented by abortion as well as the prevalence of contraceptive use in the population,[10] the index can be used to estimate the level of fertility that would exist in the absence of abortion. This hypothetical TFR is computed by dividing the TFR implied by the Bongaarts model (shown in column 7 of Table 2) by the index of abortion (column 5); the difference between the hypothetical TFR and the implied TFR represents the absolute effect of abortion on fertility. The results for the 11 countries are shown in columns 9 and 10.

One qualification must be noted at this point. The assumption of "other things being equal" is crucial to the analysis; in reality, a proportion of the births averted by legal induced abortion would be averted by other means—probably contraception, abstinence or illegal abortion—in the absence of legal abortion. For example, after abortion was restricted in Romania in late 1966, the total legal abortion rate plunged from 6.6 to 1.4 abortions per woman between 1966 and 1967, while the total fertility rate rose from 1.9 to 3.7 births per woman. Had all the induced abortions been transformed into live births, a much higher TFR (about 5.4) would have resulted.

As the last two columns of Table 2 illustrate, abortion has had a substantial absolute effect on fertility in the Eastern European countries with a high incidence of abortion. In Bulgaria in 1976, for example, fertility could have been about 60 percent higher had there been no induced abortions, and in Hungary in 1966, it could have been almost 90 percent higher. Elsewhere in the region, the hypothetical TFR could have been high-

Table 2. Total legal abortion rates, estimated indices of fertility-inhibiting factors, and implied and hypothetical total fertility rates (TFRs) for selected countries, 1959–1982

Country	Year	Total abortion rate	Index				Implied TFR*	Hypothetical TFR	Difference between hypothetical & implied TFR	
			C_m	C_c	C_a	C_i			Abs.	%
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Eastern Europe										
Bulgaria	1976	1.9	0.64	0.35	0.63	0.93	2.04	3.24	1.20	59
Czechoslovakia	1959	0.9	0.61	0.36	0.80	0.93	2.46	3.08	0.62	25
	1970	1.0	0.58	0.34	0.76	0.93	2.13	2.80	0.67	31
Hungary	1966	2.5	0.61	0.41	0.53	0.94	1.93	3.64	1.71	87
	1977	1.2	0.64	0.27	0.73	0.95	1.91	2.62	0.71	37
Poland†	1972	0.5	0.52	0.41	0.88	0.95	2.74	3.11	0.37	14
Yugoslavia	1970	1.3	0.60	0.36	0.75	0.95	2.36	3.15	0.79	33
Other										
Denmark	1970	0.3	0.56	0.27	0.94	0.93	2.03	2.16	0.13‡	6‡
Finland	1971	0.6	0.51	0.17	0.89	0.93	1.11	1.25	0.14‡	13‡
Israel	1982	0.9	0.45	0.34–0.45	0.82–0.84	0.93	2.13	2.57	0.44	21
United States	1965	0.0	0.61	0.31	1.00	0.93	2.72	2.72	0.00	0
	1973	0.5	0.57	0.22	0.95	0.93	1.67	1.76	0.09‡	5‡
Cuba	1972	1.6	0.69	0.52	0.79	0.90	3.89	4.92	1.03	26
Korea, Rep. of	1960	0.5	0.72	0.97	0.97	0.56	6.13	6.32	0.19	3
	1970	1.5	0.58	0.77	0.82	0.86	3.81	4.65	0.84	22

*Implied by Bongaarts model ($TFR = C_m \times C_c \times C_a \times C_i \times 15.3$). The indices shown have been rounded; the implied TFRs shown have been computed by using unrounded indices in the equation.

†Reporting of abortions incomplete.

‡Relatively large underestimate because a large proportion of abortions were obtained by unmarried women.

Sources: **Cuba**—P. Hollerbach and S. Díaz-Briquets, "Fertility Determinants in Cuba," Working Paper No. 102, Center for Policy Studies, The Population Council, New York, 1983; **Israel**—E. F. Sabatello, 1985 (see sources to Table 1); **Hungary (1966), Poland, Yugoslavia, Denmark, Finland and Korea**—see reference 3; **all other countries**—author's calculations.

er by 25–37 percent. Expressed as the average number of births averted per woman, the absolute effect of abortion ranged from about two-thirds of a birth in Czechoslovakia in 1959 and 1970 to nearly one and three-quarters in Hungary in 1966. (Underreporting of induced abortions in Poland explains the difference between the figures for that country and the results for the rest of eastern Europe.[11]) In Romania and the Soviet Union, where total abortion rates as high as 5.0–7.5 were recorded in the 1960s,[12] the absolute effect of abortion on fertility must have been at least double the effect estimated for Hungary in 1966. Although data for reliable calculations are not available, it appears likely that three or more births per woman were being averted by induced abortion in Romania and the Soviet Union during those years (not shown).

The results for the United States in 1973 and for Denmark and Finland are incompatible with the total abortion rates shown in the table, and appear to be large underestimates. The reason is that large proportions of abortions in these three countries are obtained by unmarried women; for example, during the 1970s in the United States, only about 20–30 percent of induced abortions occurred among currently married women.[13] The data for Israel in 1982, when the total abortion rate was 0.9, suggest that 0.4 births per woman were averted; had no abortions been performed, the TFR would have increased 21 percent.

Had no abortions been performed in South Korea in 1960, when the total abortion rate equaled 0.5, fertility would have been only three percent higher. By 1970, the total abortion rate had tripled, to 1.5 procedures per woman, and the number of births averted had quadrupled, from 0.2 to 0.8 per woman; elimination of induced abortion would have increased fertility by 22 percent. Since the incidence of induced abortion continued to rise during the 1970s, it is reasonable to assume that the total fertility rate in the mid-1970s could have been one-quarter to one-third higher in the absence of abortion than it actually was. As for Cuba, the data indicate that in 1972, one birth per woman was being averted by abortion, and fertility would have increased by 26 percent without abortion utilization.

Relationship of Contraception And Abortion

In low-fertility countries where contraceptive practice is extensive and highly effective contraceptives are widely used, the incidence of induced abortion is likely to be moderate to low. Except for the United States and Israel, the more developed Western countries have total abortion rates no higher than 0.6 and, almost without exception, contraceptive prevalence rates of at least 70 percent of married women of childbearing age.[14] In Eastern Europe, it is precisely in those countries where contraceptive practice is relatively widespread—Czechoslovakia, the German Democratic Republic and Hungary—that the level of abortion is comparatively low; in the latter two countries, moreover, total abortion rates have been declining.[15] The role of contraceptive practice in reducing recourse to abortion is illustrated by Hungary between the late 1960s and the late 1970s. In 1966, 68 percent of married women of reproductive age were using a contraceptive method; of this group, however, 79 percent were using withdrawal or condoms, and none were using the pill or the IUD. By 1977, when the contraceptive prevalence rate equaled 73 percent of married women, only 25 percent of users were relying on the former two methods, and 69 percent were relying on the pill or the IUD.[16] During approximately the same period, the incidence of abortion declined substantially, from a total abortion rate of 2.5 abortions per woman to a rate of 1.1 (see Table 1).

In Japan, an increase in contraceptive prevalence was primarily responsible for the decline in the level of abortion that occurred between the 1950s and the 1970s (the total abortion rate was 4.0 in 1955 and 2.5 in 1975). One researcher has estimated that the ratio of births prevented by contraceptive practice to births prevented by abortion shifted from 100:257 in 1955 to 100:85 in 1970.[17]

An inverse relationship between abortion and contraception is not, however, the only pattern possible. Induced abortion and contraceptive practice can increase concurrently—a trend that is likely to occur during periods of rapid fertility decline. Such was the experience of South Korea in the 1960s (as shown in Table 2) and of China in the 1970s and early 1980s. In China, for example, the annual number of abortions equaled 4–5 million during 1971–1978 and then increased to 12 million in 1982. Other "birth control operations," that is, IUD insertions and sterilizations, fluctuated between nine million and 24 million per year during the same period.[18]

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Unintended Pregnancy Among American Women

By Jacqueline Darroch Forrest

The following research note presents new estimates of the proportion of American women of reproductive age who experience unintended pregnancies, unintended births and abortions. The data are based on tabulations from the 1982 National Survey of Family Growth (NSFG) and The Alan Guttmacher Institute's 1981–1982 national survey of abortion providers.

In 1982, some 6.1 million women became pregnant. Of these, 3.7 million gave birth,[1] 1.6 million had abortions[2] and 0.9 million experienced miscarriages.* An estimated 37 percent of all births in the five years preceding the 1982 NSFG were unintended—that is, the women either had wanted those births at a later time (27 percent) or had not wanted them ever (10 percent).[3] Applying that proportion to 1982 births results in an estimate of 1.3 million unintended births. In addition, it can be assumed that all 1.6 million abortions were terminations of unintended pregnancies. Adding these two numbers to an estimate of 0.4 million unintended pregnancies that were miscarried yields a total of 3.3 million pregnancies in 1982 (54 percent of all pregnancies in that year) that were not intended. These figures mean that 11 percent of the 54.7 million women aged 15–44[4] became pregnant, six percent unintentionally.

Table 1. Reported and adjusted percentage of U.S. women aged 15–44 who had ever had an unintended pregnancy that ended as a birth or an abortion, 1982 NSFG

Category	Reported	Adjusted*
(1) Total unintended birth	**32.7**	**32.7**
(2) Unintended birth only	29.0	24.8
(3) Unintended birth and abortion	3.7	7.9
(4) Abortion only	**6.2**	**13.2**
(5) Total abortion (rows 3 + 4)	9.9	21.1
(6) Unintended pregnancy (rows 1 + 4)	**38.9**	**45.9**

*Adjusted for underreporting of abortions, based on the assumption that the proportion of women reporting abortions was 47 percent of those who actually obtained them.

The proportion of women who experience an unintended pregnancy during their lives is, of course, greater than the annual proportion who do so. Respondents in the 1982 NSFG reported that 40 percent of the births they had ever had were unintended.[5] However, the proportion of women ever experiencing an unintended birth was actually somewhat lower, since 37 percent of the respondents reported more than one unintended birth.[6] As Table 1 shows, 33 percent of NSFG respondents said that they had had at least one unintended birth during their lives; this group includes respondents (constituting four percent of all women aged 15–44) who said that they had had both an unintended birth and an abortion. Another six percent of NSFG participants said they had never had an unintended birth but had had an abortion, bringing to 10 percent the total proportion who reported having undergone an abortion.

Abortions were, however, seriously underreported in the NSFG, as they have been in most other surveys.[7] Only 47 percent of the abortions that occurred during the period 1977–1981 were reported.[8] Assuming that this degree of underreporting applies equally to NSFG respondents who had experienced both an unintended birth and an abortion and to those who had had only an abortion, then the former group actually constituted eight percent of all women aged 15–44 (rather than the four percent reported), and the latter group constituted 13 percent (rather than six percent). Thus, the real proportion of women of reproductive age who have ever had an abortion appears to be 21 percent, and not the 10 percent indicated by the NSFG. (This revised figure is similar to an earlier estimate that 18 percent of women aged 18–44 in 1981 had obtained abortions since 1967.[9]) Since there is no reason to believe that NSFG respondents underreported

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*Estimated as 20 percent of births plus 10 percent of abortions.

Table 2. Percentage of women estimated to have ever had an unintended pregnancy or an abortion, by age-group, 1982

Age	Pregnancy	Abortion
Total	**45.9**	**21.1**
15–19	18.7	13.7
20–24	41.5	27.0
25–29	46.1	19.5
30–34	53.6	18.4
35–39	54.2	14.1
40–44	65.0	23.1

Sources: Estimated from the 1982 NSFG with adjustments for the overall underreporting of abortions in 1977–1981 and for age differences in abortion underreporting in 1981 (see: W. Pratt, "Abortion Reporting in the 1982 NSFG," memorandum, National Center for Health Statistics [NCHS], Hyattsville, Md., 1985).

Table 3. Rate of abortions and of first abortions per 1,000 women, and cumulative rate of first abortions per 1,000 women, by age-group, 1982

Age	Abortion rate	1st abortions as % of all abortions	1st-abortion rate	Cum. 1st-abortion rate*
<15	8.3	93.9	7.8	7.8
15–17	30.1	86.5	26.0	85.8
18–19	60.0	75.6	45.4	176.6
20–24	51.2	59.2	30.3	328.1
25–29	31.5	49.7	15.7	406.6
30–34	17.7	40.0	7.1	442.1
35–39	9.3	30.0	2.8	456.1
40–44	3.3	20.0	0.7	459.6

*Number having an abortion by end of specific age-penod, per 1,000 women.

Sources: **Abortion rate:** S. K. Henshaw, "Characteristics of U.S. Women Having Abortions, 1982–1983," *Family Planning Perspectives*, 19:5, 1987; **percentage of abortions that were first abortions:** **<15–29:** average of levels for 1981 and 1983 from NCHS, "Induced Terminations of Pregnancy: Reporting States, 1981," and "..., 1982 and 1983," *Monthly Vital Statistics Report*, Vol. 34, No. 4, Supplement (2), 1985, and Vol. 35, No. 3, Supplement, 1986; **30–44:** estimates used are lower than those reported by the NCHS, because these age-groups did not have access to legal abortion in the early part of their reproductive lives, whereas younger women have had such access. We have assumed, therefore, that when women who are now beginning their reproductive lives reach ages 30–44, any abortions they then obtain will be less likely to be first abortions than is the case among women currently 30–44.

the unintended births they had had, the proportion of women who have had only an unintended birth appears to be 25 percent rather than 29 percent (the other four percent being those women who reported an unintended birth but failed to report an abortion). In all, these adjusted estimates indicate that 46 percent of U.S. women aged 15–44, rather than 39 percent, have experienced at least one unintended pregnancy in their lives.*

The figures presented so far are based on an average of the differing exposure of older and younger women to the risk of unintended pregnancy, as well as the differing availability of legal abortion during their lifetimes. In 1982, women aged 15–24 were the only ones who had had access to legal abortion throughout their reproductive years. As Table 2 illustrates, 65 percent of all women aged 40–44 in 1982 had had at least one unintended pregnancy, and more than one-third of them (23 percent of all women aged 40–44) had had at least one abortion.

However, it is probably inappropriate to view these levels as representative of the proportions of today's young women who will ever experience an unintended pregnancy or abortion. In the first place, when the older women began their reproductive lives, during the mid-1950s, the more effective methods of contraception were not available. The use of these methods by today's young women presumably will reduce the cumulative incidence of unintended pregnancy. Second, our estimate of the proportion of older women who have had an abortion will be low if such women are less likely to report procedures performed many years ago—when they were illegal—than procedures performed more recently. But even if the estimate is low, women turning 15 during the 1980s will probably be more likely to ever obtain an abortion than were those who turned 15 during the 1950s. Indeed, as Table 2 shows, an estimated 27 percent of 20–24-year-olds in 1982 had already had an abortion, compared with 23 percent of women aged 40–44 in that year.

It is difficult to estimate the extent to which the level of unintended pregnancy will change, partly because it is unclear to what extent current abortions represent additional unintended pregnancies rather than pregnancies that in earlier years would have been carried to term.[10] However, we can estimate the proportion of women who will have had an abortion by age 45 if current rates of abortion continue. To compute this estimate—the cumulative rate of first abortions—we have adjusted the 1982 abortion rate for each age-group by the proportion of abortions that were first procedures, and then multiplied the adjusted rate by the number of years in each age-group (see Table 3). The results indicate that 18 percent of women will have had a first abortion by age 20, 41 percent will have had one by age 30, and 46 percent, by age 45.

We do not know whether current abortion rates will continue, but if they do, then nearly half of U.S. women can be expected to undergo an abortion at least once during their lives. Furthermore, if the lifetime rate of unintended pregnancy remains at the 65 percent level estimated for women aged 40–44 in 1982, then current abortion rates imply that about 70 percent of women who experience an unintended pregnancy will have at least one abortion.

*These figures do not include any estimate for unintended pregnancies ending only in miscarriage.

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SURVEY METHODOLOGY AND QUESTIONNAIRES

SURVEY METHODOLOGY

Introduction

In order to monitor the availability and accessibility of legal abortion services in the United States, the AGI has periodically surveyed all identified providers of abortion services. The first six AGI Abortion Provider Surveys were conducted annually between 1974 and 1979, with each gathering data for the preceding year, from 1973 through 1978. The seventh, eighth, and ninth surveys were conducted in 1981, 1983, and 1986 respectively, and each gathered data for the two preceding years, 1979-1980, 1981-1982, and 1984-1985. Data were not collected for the year 1983. The ninth survey, which supplied the data for much of the research reported in this volume, asked providers to report the number of abortions performed in 1984 and 1985. Nonhospital providers were asked to answer additional questions about harassment, malpractice insurance, Medicaid, anesthesia, and charges for first-trimester abortions.

The basic methodology of the survey has remained consistent throughout the years, except for the length of time covered by each survey and the addition of questions on special topics. Also, the routine methods for locating potential providers of abortion services have on occasion been supplemented by random surveys of potential providers and other special efforts.

A. The Survey Universe

The Alan Guttmacher Institute attempts to locate all facilities in the United States - including hospitals, clinics and physician's offices - in which abortion services are provided. For each survey, the master file of abortion providers derived from the prior survey has been updated with names obtained by the following methods:

1) All Planned Parenthood affiliates and National Abortion Rights Action League (NARAL) state coordinators have been asked to provide a current listing of abortion service providers in their state and/or local areas.

2) State health departments have been asked to provide detailed listings of the facilities which reported having performed abortions during the current survey years.

3) Beginning with the survey fielded in 1983, the telephone yellow pages of major metropolitan areas have been checked for providers advertising abortion services that were not already included in the AGI file.

4) Newspaper articles from a national clipping service have been monitored for references to abortion service providers who were not included in the AGI comprehensive listing.

5) Mailing lists from companies and other organizations have been used when available.

For the 1984-1985 survey, these combined sources yielded a survey universe of 3,853 possible providers - 1,574 hospitals, 990 nonhospital clinics and 1,289 physician offices. Of these, 3216 had been contacted in the previous survey, and 637 were newly identified as actual or likely providers of abortion services. It turned out that only 251 of the newly identified facilities actually provided abortions in 1984 or 1985, 46 of which were identified from telephone yellow pages.

Of the facilities on the master provider list from earlier surveys, 150 had not reported any abortions in 1982 but did report some in 1984 or 1985. In addition, 22 new providers were identified from state health department records; the health department data were used for these providers, and they were not sent questionnaires.

B. Fielding the Survey

In March, 1986, questionnaires tailored to each of the three types of providers were mailed to all of the hospitals, clinics and physicians in the survey universe. The questionnaires are reproduced on the following pages. The first question verified the provision of abortion services in 1984 or 1985. If abortions were performed, respondents were asked to provide the exact number or best estimate of the number they performed in 1984 and 1985, and the number or percent that were performed past 12 weeks LMP (since last menstrual period). Additional survey topics included the limit on the gestational age at which abortions would be performed in a facility, provider acceptance of Medicaid reimbursement as payment for abortion, charges for nonhospital abortion services, and harassment by anti-abortion activists.

Two or three follow-up mailings were sent to facilities which did not respond to the earlier mailings. For nonhospital facilities which had reported fewer than 400 abortions in 1982, the third follow-up mailing asked only for the number of abortions done in 1984 and 1985 in a single question at the bottom of the letter. This question produced a good response, thereby saving staff time and expense.

For facilities which had not responded after three or four mailings, state health department data were used when available. Otherwise, the facilities were contacted by telephone and asked to complete questions 1, 2, 4, 5, and 6 of the survey with a telephone interviewer. Respondents who agreed to cooperate, but did not have the information readily available, were sent a written questionnaire which they were urged to complete and return. As many as six calls (and sometimes twice that many) were made to some respondents. The more rigorous effort, with more phone calls, was made to facilities that provided 400 or more abortions in 1982. In a few instances when these efforts were unsuccessful, estimates were obtained from other persons in the providers' community who were knowledgeable about local abortion services.

In the past, state health department reports had been enormously helpful in cutting down on the number of follow-up telephone calls. In recent years, however, many states have instituted policies of confidentiality which prohibit the release of any facility-specific data on abortion. These policies are designed to encourage provider participation in data collection efforts by ensuring that no information about individual providers will be made public. In the wake of escalated harrassment by abortion opponents, providers have become increasingly wary of releasing any information about their practices without strict assurance of confidentiality. The AGI takes great care to keep facility-level data confidential, and makes such assurances in a cover letter which accompanies the survey form, as well as in follow-up telephone conversations with providers.

C. Completion Rates

Of the survey universe of 3,873 facilities (including 22 new providers identified from health department reports), it was ascertained that 2,680 provided abortions in 1985 and 827 did not. It was assumed that no abortions were provided by an additional 130 facilities that did not respond to the survey but had reported no abortions in 1982. The remaining 203 refused to cooperate: 64 hospitals, 41 clinics, and 98 physicians. The refusal rate was therefore six percent.

For those facilities for which data were obtained, the sources of the data were: the mailed questionnaire, 69 percent, including some who returned the questionnaire after being urged by telephone to do so; health department reports, 10 percent; and telephone interviews with providers, 18 percent. In the remainder of the cases, information was obtained from other sources connected to the provision of abortion services.

D. Estimates of Under-reporting

Since the majority of providers in the AGI survey universe are identified through Planned Parenthood affiliates and NARAL coordinators, it is likely that we identified and surveyed almost all major providers but missed some small hospital and physician providers. In addition to the information from Planned Parenthood and NARAL coordinators, 12 state health departments furnished us with lists of data which included the names of individual facilities. (Many other states provided county-level data on abortion.) The completeness of health department data varies widely in those states which require reporting; there is variation in the types of providers that must report, in the completeness of reporting, and in the follow-up performed by the health department. The names on the health department lists were most often restricted to those of hospital and clinic providers. In general, hospitals and licensed outpatient clinics are the most likely types of facilities to be identified in state health department reports regardless of the size of their abortion caseloads. For the 1984-1985 survey, we did not receive any state-specific listings from Planned Parenthoods, NARAL affiliates or state health departments in Arkansas, Maine, Mississippi or South Dakota.

The AGI has conducted supplemental sample surveys of hospitals and physicians which help to assess the extent to which abortions are undercounted in the AGI Abortion Provider Survey. The last survey of American Hospital Association members was conducted in March, 1980 for the 1978 survey. Based upon the results of this survey it was estimated that an additional 800 abortions were performed in hospitals that were not identified in the 1978 AGI survey. But in more recent years, hospitals have tended not to be as undercounted as in the past. Most states require hospitals to report data on abortion to the state health department. Through state health department reports, we identified 47 new hospitals in the 1981-1982 survey and six new hospitals in the 1984-1985 survey. Overall, in the 1984-1985 survey, hospitals accounted for 85 percent of all the data obtained from health department reports.

The proportion of abortions being performed in hospitals, however, has been declining, while the proportion in nonhospital clinic and physicians' offices has been steadily increasing. The AGI estimated that the 1977 provider survey undercounted physicians' office abortions by 68,000. From the 1983 AGI survey of private physicians, it was estimated that the Abortion Provider Survey missed about half of the physicians who performed abortions in their offices in 1981 and 1982, and that these physicians provided a projected 110,000 abortions in 1982. The large majority of physicians and hospitals missed in the survey provide only a small number of abortions per year.

E. Methodology for Computation of Abortions by State of Residence

Following the procedure used in 1978-1981, estimates of 1982 resident abortions in each state were derived from data obtained from the CDC and AGI's abortion survey results. The first step was to calculate the percentage of each state's abortions that occurred to residents of that state, using the CDC data. This proportion was applied to AGI's count of abortions occurring in each state to estimate the number of abortions occurring in that state to state residents. The remaining abortions were obtained by residents of other states. The second step was to distribute the nonresident abortions to the appropriate states according to the percentage distribution indicated in work sheets provided by the CDC. The CDC work sheets show the state of residence of women obtaining abortions in each state for which data are available from the state health department.

State health department data on state of residence of women obtaining abortions were unavailable or considered unreliable in 9 states in 1982: Alaska, Delaware, Florida, Kentucky, Massachusetts, Michigan, Ohio, Wisconsin and Wyoming. Alaska was assumed to provide no abortions to residents of other states. For the remaining 8 states, a special telephone survey of large clinic and hospital providers was conducted for 1981 and 1982 data, and the results were assumed to be applicable to all abortions occurring in the states.

F. Estimation of Numbers of Women Obtaining Abortions, by Selected Characteristics

To estimate the numbers of women obtaining abortions by such characteristics as age, race, marital status and length of gestation, distributions compiled by the CDC have been adjusted and applied to the numbers of abortions that were reported to AGI.

The CDC distributions are based on data provided by those states which collect data on characteristics. Since the states collecting such data vary somewhat from year to year, the CDC percentage distributions have been adjusted to eliminate any year-to-year fluctuations caused by the addition of new states to the data set, the loss of other states that stopped collecting the data, year-to-year changes in the definitions used by a state and year-to-year changes in the percentage of a state's abortions for which the particular characteristic was unknown or unspecified. To remove these effects, the year for which the most complete data are available, 1976, was taken as the base year. Year-to-year changes, both forward and backward from 1976, were calculated using only the states for which comparable data were available for both years being compared. The distribution of a characteristic for a particular year (e.g. the age distribution) was calculated by applying the cumulative change between that year and 1976 to the 1976 distribution. The calculated percentage distribution was then applied to the total number of abortions for that year to get the number of abortions in each category (for example, the number of abortions occurring to women under age 20).

The following additional adjustments have been made to the CDC distributions:

Weeks of gestation and method: Since AGI obtains reports from relatively more clinics and private physicians than CDC does, it was assumed that one-half of the difference between the AGI and CDC totals represented abortions in nonhospital clinics and physicians' offices, performed at 12 weeks' gestation or less by suction curettage. These cases were distributed by duration of pregnancy according to the distribution of all CDC cases with known gestation of 12 weeks or less. The other half of the difference was distributed according to the CDC proportion for all cases for which the length of gestation or method of abortion was known.

The CDC's marital status categories were changed in 1978 to include "separated" with "married" rather than with "unmarried," as was done in previous years. To make the 1978 and later data comparable to those for earlier years, the 1978 percentage distribution was adjusted on the basis of an estimate of the magnitude of the effect of the definitional change. For many states this change had no effect; most of these states simply recorded whether women obtaining abortions were married or unmarried, so that separated women could have been counted in either category at the discretion of the individuals filling out the pregnancy termination forms. In the states where separated women are tabulated separately, an estimate of the effect of the definitional change was made on the basis of the nine states for which the number of separated women obtaining abortions was available from the CDC. Changes from 1978 to 1979, from 1979 to 1980, and from 1980 to 1981 were calculated in the usual manner.

G. Geographic Coding

Data for metropolitan areas are presented for Standard Metropolitan Statistical Areas (SMSAs) and New England County Metropolitan Areas (NECMAs) as defined by the Office of Management and Budget after the 1980 census.

In New England, where SMSAs are officially defined in terms of cities and towns rather than counties, the Bureau of the Census has developed NECMAs for use when publishing population data available only by county. Because the geographic coding system used for the Abortion Provider Survey is based on counties, the 15 NECMAs have been substituted for the New England SMSAs.

HOSPITAL

The Alan Guttmacher Institute

An Independent, Non-Profit Corporation for Research, Policy Analysis and Public Education

111 Fifth Avenue New York, New York 10003 Telephone 212-254-5656

Name of Individual Completing Form

Telephone

Date

CD(
(1–11)

1. Were either in-patient or out-patient abortions (including endometrial aspirations, "menstrual regulation") performed at the hospital during calendar year 1984 or 1985? PLEASE DO NOT INCLUDE TREATMENT OF SPONTANEOUS OR INCOMPLETE ABORTIONS. (Please circle the number by the appropriate answer.)

   1 – Yes 2 – No If No: Please stop here and return the questionnaire in the enclosed envelope. It is important that the questionnaire be returned even if no abortions were performed. (12)

2. How many abortions were performed:

	In-patient	Out-patient	Total	
In 1984?	_____	_____	_____	(13–27)
In 1985?	_____	_____	_____	(28–42)

   (Please give your best estimate if you do not have the exact number.)

3. Of the abortions reported above, please indicate either the number or the percent that occurred past 12 weeks LMP (since last menstrual period).

   In 1984? _____ Estimated number or _____ Estimated percent (43–46, 47–48)

   In 1985? _____ Estimated number or _____ Estimated percent (49–52, 53–54)

4. What is generally the maximum gestation (in weeks LMP) of abortions provided in the hospital? _____ weeks (55–56)

5. In 1985, was there pressure from outside the hospital to restrict or eliminate abortion services?

   1 – Yes 2 – No 3 – Don't know (57)

   Was there more or less pressure in 1985 than in 1984?

   1 – No pressure either year

   2 – More in 1985

   3 – More in 1984

   4 – No change

   5 – Don't know (58)

Thank you for your assistance.

The Alan Guttmacher Institute

An Independent, Non-Profit Corporation for Research, Policy Analysis and Public Education

111 Fifth Avenue New York, New York 10003 Telephone 212-254-5656

Name of Individual Completing Form

Telephone Number

Date

CO1
(1-11)

1. Were any abortions (including endometrial aspirations, "menstrual regulation") performed in your office during calendar year 1984 or 1985? If yours is a group practice, this questionnaire applies to the entire group. (Please circle the number by the appropriate answer.)

   1 – Yes 2 – No If No: Please stop here and return the questionnaire in the enclosed envelope. It is important that the questionnaire be returned even if no abortions were performed. (12)

2. How many abortions were performed in your office? (Please give your best estimate if you do not have the exact number.)

   In 1984: _____ In 1985: _____ (23-27, 38-42)

   Are you responding for your entire group?

   1 – Solo practice 2 – Yes 3 – No If No: What are the names of other physicians in your group providing office abortions?

   _____

   _____

3. Of the abortions in your office reported above, please indicate either the number or the percent that occurred past 12 weeks LMP (since last menstrual period).

   In 1984? _____ Estimated number or _____ Estimated percent (43-46, 47-48)

   In 1985? _____ Estimated number or _____ Estimated percent (49-52, 53-54)

4. What is generally the maximum gestation (in weeks LMP) of abortions provided in your office by instrumental evacuation (not instillation)? _____ weeks (55-56)

5. About what percent of the patient visits to your group or practice at this location are for abortion services?

   1 – 75% or more 2 – 50–74% 3 – 25–49% 4 – 10–24% 5 – less than 10% (57)

6. What are the usual charges a patient would incur for an abortion performed in your office at 10 weeks LMP? Please include fees for any services you always require for an abortion patient (e.g., pregnancy and lab tests, additional office visits), even if these are not billed through you.

   With local anesthesia $ _____ With general anesthesia $ _____ (58-60, 61-63)

7. Approximately what number or percent of abortions in 1985 were paid for by Medicaid or a state abortion fund?

   _____ number or _____ % (64-67, 68-69)

   If you are unable to give an exact number or percent above, please circle the most appropriate range below:

   1 – none 2 – <2% 3 – 2–4% 4 – 5–9%

   5 – 10–24% 6 – 25–49% 7 – 50%+ 8 – Some, don't know percent (70)

8. Approximately what number or percent of abortions in 1985 were provided at a reduced fee or free (other than those billed to Medicaid or to an insurance company)?

   _____ number or _____ % (71-74, 75-76)

   If you are unable to give an exact number or percentage above, please circle the most appropriate range below:

   1 – none 2 – <2% 3 – 2–4% 4 – 5–9%

   5 – 10–24% 6 – 25–49% 7 – 50%+ 8 – Some, don't know percent (77)

9. Approximately what number or percent of your first-trimester abortion patients in 1985 received each of the following types of anesthesia? (80-1) CD2 (1-11)

General anesthesia	_____ number or _____ %	(12-16, 17-18)
Local (including paracervical) or combination local and IV sedative	_____ number or _____ %	(19-23, 24-25)
None or IV sedative only	_____ number or _____ %	(26-30, 31-32)
	Total 100%	

The following special questions in this year's survey concern environmental pressures that may affect the way you provide abortion services.

10. How many times did each of the following anti-abortion activities occur at your facility in 1985? Did they occur more or less often in 1985 than in 1984?

	Number of times in 1985					1985 Compared with 1984			
	0	1	2-4	5-19	20+	More	Less	No Change	
• Picketing	a	b	c	d	e	1	2	3	(33, 34)
• Picketing with physical contact or blocking of patients	a	b	c	d	e	1	2	3	(35, 36)
• Picketing with noise loud enough to be heard inside in patient areas	a	b	c	d	e	1	2	3	(37, 38)
• Invasion by demonstrators	a	b	c	d	e	1	2	3	(39, 40)
• Distribution of anti-abortion literature inside your facility	a	b	c	d	e	1	2	3	(41, 42)
• False appointments made to disrupt scheduling	a	b	c	d	e	1	2	3	(43, 44)
• Jamming of telephone lines	a	b	c	d	e	1	2	3	(45, 46)
• Tracing of license plates to identify your abortion patients	a	b	c	d	e	1	2	3	(47, 48)
• Vandalism: jamming of locks, physical damage	a	b	c	d	e	1	2	3	(49, 50)
• Picketing the homes of staff members	a	b	c	d	e	1	2	3	(51, 52)
• Death threats	a	b	c	d	e	1	2	3	(53, 54)
• Bomb threats	a	b	c	d	e	1	2	3	(55, 56)
• Other: _____	a	b	c	d	e	1	2	3	(57, 58)

	Yes	No	
11. During the past 12 months, have you been notified that your malpractice insurance was being canceled or would not be renewed?	1	2	(59)
. . . . have you been notified that your fire/casualty insurance was being canceled or would not be renewed?	1	2	(60)
. . . , have you been expected or required to conform to new or newly interpreted licensing requirements?	1	2	(61)

12. Did you experience change in 1985 compared with 1984 in:

	Increased in 1985	Decreased in 1985	No change	
• difficulty hiring staff?	1	2	3	(63)
• number of security personnel employed?	1	2	3	(64)
• security expenses other than for personnel?	1	2	3	(65)
• difficulty arranging for hospital backup?	1	2	3	(66)
• legal expenses?	1	2	3	(67)

13. Has anything happened in the last 12 months that significantly increased your costs or made it more difficult for you to provide abortion services?

1 – No 2 – Yes: Specify _____ (68)

Comments: (80, 2)

Thank you for your assistance.

The Alan Guttmacher Institute

An Independent, Non-Profit Corporation for Research, Policy Analysis and Public Education

111 Fifth Avenue New York, New York 10003 Telephone 212-254-5656

Name of Individual Completing Form

Telephone Number

Date

CD1 (1–11)

1. Were any abortions (including endometrial aspirations, "menstrual regulation") performed at the clinic during calendar year 1984 or 1985? (Please circle the number by the appropriate answer.)

   1 – Yes 2 – No If No: Please stop here and return the questionnaire in the enclosed envelope. It is important that the questionnaire be returned even if no abortions were performed. (12)

2. How many abortions were performed in the clinic (excluding those performed by clinic staff in hospitals)? (Please give your best estimate if you do not have the exact number.)

   In 1984: _____ In 1985: _____ (23–27, 38–42)

3. Of the abortions reported above, please indicate either the number or the percent that occurred past 12 weeks LMP (since last menstrual period).

   In 1984? _____ Estimated number or _____ Estimated percent (43–46, 47–48)

   In 1985? _____ Estimated number or _____ Estimated percent (49–52, 53–54)

4. What is generally the maximum gestation (in weeks LMP) of abortions provided in your facility? _____ weeks (55–56)

5. About what percent of the patient visits to your organization at this location are for abortion services?

   1 – 75% or more 2 – 50–74% 3 – 25–49% 4 – 10–24% 5 – less than 10% (57)

6. What are the usual charges a patient would incur for an abortion performed in your clinic at 10 weeks LMP? Please include fees for any services you always require for an abortion patient (e.g., pregnancy and lab tests, additional clinic visits), even if these are not billed through you.

   With local anesthesia $ _____ With general anesthesia $ _____ (58–60, 61–63)

7. Approximately what number or percent of abortions in 1985 were paid for by Medicaid or a state abortion fund?

   _____ number or _____ % (64–67, 68–69)

   If you are unable to give an exact number or percent above, please circle the most appropriate range below:

   1 – none 2 – <2% 3 – 2–4% 4 – 5–9%

   5 – 10–24% 6 – 25–49% 7 – 50%+ 8 – Some, don't know percent (70)

8. Approximately what number or percent of abortions in 1985 were provided at a reduced fee or free (other than those billed to Medicaid or to an insurance company)?

   _____ number or _____ % (71–74, 75–76)

   If you are unable to give an exact number or percent above, please circle the most appropriate range below:

   1 – none 2 – <2% 3 – 2–4% 4 – 5–9%

   5 – 10–24% 6 – 25–49% 7 – 50%+ 8 – Some, don't know percent (77)

9. Approximately what number or percent of your first-trimester abortion patients in 1985 received each of the following types of anesthesia? (80–1)
   CD2 (1–11)

   General anesthesia _____ number or _____ % (12–16, 17–18)

   Local (including paracervical) or combination local and IV sedative _____ number or _____ % (19–23, 24–25)

   None or IV sedative only _____ number or _____ % (26–30, 31–32)

Total 100%

The following special questions in this year's survey concern environmental pressures that may affect the way you provide abortion services.

10. How many times did each of the following anti-abortion activities occur at your facility in 1985? Did they occur more or less often in 1985 than in 1984?

	Number of times in 1985					1985 Compared with 1984			
	0	1	2–4	5–19	20+	More	Less	No Change	
• Picketing	a	b	c	d	e	1	2	3	(33, 34)
• Picketing with physical contact or blocking of patients	a	b	c	d	e	1	2	3	(35, 36)
• Picketing with noise loud enough to be heard inside in patient areas	a	b	c	d	e	1	2	3	(37, 38)
• Invasion by demonstrators	a	b	c	d	e	1	2	3	(39, 40)
• Distribution of anti-abortion literature inside your facility	a	b	c	d	e	1	2	3	(41, 42)
• False appointments made to disrupt scheduling	a	b	c	d	e	1	2	3	(43, 44)
• Jamming of telephone lines	a	b	c	d	e	1	2	3	(45, 46)
• Tracing of license plates to identify your abortion patients	a	b	c	d	e	1	2	3	(47, 48)
• Vandalism: jamming of locks, physical damage	a	b	c	d	e	1	2	3	(49, 50)
• Picketing the homes of staff members	a	b	c	d	e	1	2	3	(51, 52)
• Death threats	a	b	c	d	e	1	2	3	(53, 54)
• Bomb threats	a	b	c	d	e	1	2	3	(55, 56)
• Other: _____	a	b	c	d	e	1	2	3	(57, 58)

	Yes	No	
11. During the past 12 months, have you been notified that your malpractice insurance was being canceled or would not be renewed?	1	2	(59)
. . . . have you been notified that your fire/casualty insurance was being canceled or would not be renewed?	1	2	(60)
. . . . have you been expected or required to conform to new or newly interpreted licensing requirements?	1	2	(61)

12. Did you experience change in 1985 compared with 1984 in:	Increased in 1985	Decreased in 1985	No change	
• difficulty hiring physicians or a medical director?	1	2	3	(62)
• difficulty hiring other staff?	1	2	3	(63)
• number of security personnel employed?	1	2	3	(64)
• security expenses other than for personnel?	1	2	3	(65)
• difficulty arranging for hospital backup?	1	2	3	(66)
• legal expenses?	1	2	3	(67)

13. Has anything happened in the last 12 months that significantly increased your costs or made it more difficult for you to provide abortion services?

1 – No 2 – Yes: Specify _____ (68)

Comments: (80 2)

Thank you for your assistance.

DETAILED TABLES

INTRODUCTION AND NOTES TO DETAILED TABLES

The tables in this section present the time series from 1973 to 1983 of the characteristics of women having abortions in the United States, detailed information about abortion services in states and metropolitan areas in 1984 and 1985, and teenage pregnancy statistics by state for 1982.

Numbers of abortions are rounded to the nearest 10 in all tables. If a provider reported one to four abortions, the number is rounded to zero. Thus it is possible for an area to be listed as having abortion providers but no reported abortions if the providers each reported fewer than five abortions during the year.

Some respondents to the AGI Provider Survey prefer not to make public the number of abortions they performed. In order to keep the information we receive from the Abortion Provider Survey confidential, we have suppressed certain data in Tables 5 and 7 which might have allowed inferences to be made about individual abortion providers.

Tables 1-4 show the characteristics (numbers, percentage distributions, rates, and ratios) of women obtaining abortions during each year between 1973 and 1983. Tables 5 and 6 show abortion services by Standard Metropolitan Statistical Area (SMSA), as defined by the Office of Management and Budget after the 1980 census. (For New England states, New England County Metropolitan Areas are used.) Table 7 gives the number of hospital and nonhospital providers in each state and the number of abortions performed by each type of provider. Tables 8 and 9 show the estimated number of abortions occurring in each state and the abortion occurrence rate for the years 1973-1985. Data for 1983 are not shown in Tables 8-9 because the AGI surveys did not cover that year.

Readers should note that the numbers of abortions and rates shown in Tables 5-9 reflect the abortions occurring in the areas, not the numbers of resident women who obtained abortions. Some metropolitan areas and states provide abortion services to large numbers of women from outside the areas and states.

Tables 10 and 11 show numbers and rates according to the state of residence of the woman. Only the years 1978-1982 are shown because a different method was used to estimate abortions by residence prior to 1978; data for years since 1982 are unavailable. (A minor change in the method of calculating state of residence also occurred between 1978 and 1979.)

Tables 12-15 show teenage birth, abortion and pregnancy rates by state. The numbers of abortions are estimated from the proportions of abortions obtained by the various age groups as given by state health department data, and the number of abortions obtained by state residents as estimated by the AGI (shown in Table 10). Since the proportions are based on state of occurrence, the procedure assumes that teenagers obtain out-of-state abortions in about the same proportions as do older women in the same state. For states with no health department data on the ages of women having abortions, the proportions of teenage abortions were estimated from similar nearby states for which data were available.

Table 1. Number and percentage distribution of legal abortions, abortion rate per 1,000 women, and percentage of pregnancies terminated by abortion, by age, United States, 1973-1983.

Measure	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Number of abortions											
Total	744,610	898,570	1,034,170	1,179,300	1,316,700	1,409,600	1,497,670	1,553,890	1,577,340	1,573,920	1,575,000
<15	11,630	13,420	15,260	15,820	15,650	15,110	16,220	15,340	15,240	14,590	16,350
15-19	232,440	278,280	324,930	362,680	396,630	418,790	444,600	444,780	433,330	418,740	411,330
15-17	n.a.	n.a.	n.a.	(152,700)	(165,610)	(169,270)	(178,570)	(183,350)	(175,932)	(168,410)	(166,440)
18-19	n.a.	n.a.	n.a.	(209,980)	(231,020)	(249,520)	(266,030)	(261,430)	(257,398)	(250,330)	(244,890)
20-24	240,610	286,600	331,640	392,280	449,660	489,410	525,710	549,410	554,940	551,680	548,130
25-29	129,600	162,690	188,900	220,500	246,680	265,990	284,200	303,820	316,260	326,380	328,280
30-34	72,550	89,810	100,170	110,050	124,380	134,280	141,970	153,060	167,240	168,020	171,560
35-39	40,960	48,770	52,740	56,720	61,700	65,350	65,070	66,580	69,510	73,250	78,090
≥40	16,820	19,000	20,530	21,250	22,000	20,670	19,900	20,900	20,820	21,260	21,260
Percentage distribution of abortions											
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<15	1.6	1.5	1.5	1.3	1.2	1.1	1.1	1.0	1.0	0.9	1.0
15-19	31.2	31.0	31.4	30.8	30.1	29.7	29.7	28.6	27.5	26.6	26.1
15-17	n.a.	n.a.	n.a.	(13.0)	(12.6)	(12.0)	(11.9)	(11.8)	(11.2)	(10.7)	(10.6)
18-19	n.a.	n.a.	n.a.	(17.8)	(17.5)	(17.7)	(17.8)	(16.8)	(16.3)	(15.9)	(15.5)
20-24	32.3	31.9	32.1	33.3	34.2	34.7	35.1	35.4	35.2	35.0	34.8
25-29	17.4	18.1	18.2	18.7	18.7	18.9	19.0	19.6	20.0	20.7	20.8
30-34	9.7	10.0	9.7	9.3	9.4	9.5	9.5	9.8	10.6	10.7	10.9
35-39	5.5	5.4	5.1	4.1	4.7	4.6	4.3	4.3	4.4	4.7	5.0
≥40	2.3	2.1	2.0	1.8	1.7	1.5	1.3	1.3	1.3	1.4	1.4
Abortion rate*											
Total	16.3	19.3	21.7	24.2	26.4	27.7	28.8	29.3	29.3	28.8	28.5
<15†	5.6	6.4	7.2	7.6	7.6	7.5	8.3	8.4	8.6	8.3	9.1
15-19	22.8	26.9	31.0	34.3	37.5	39.7	42.4	42.9	43.3	42.9	43.5
15-17	n.a.	n.a.	n.a.	(24.2)	(26.2)	(26.9)	(28.8)	(30.2)	(30.1)	(30.1)	(30.8)
18-19	n.a.	n.a.	n.a.	(49.3)	(54.1)	(58.4)	(61.9)	(61.0)	(61.8)	(60.0)	(60.4)
20-24	26.2	30.4	34.3	39.6	44.3	47.2	49.9	51.4	51.1	51.2	51.1
25-29	16.4	19.6	21.8	24.1	26.9	28.4	29.6	30.8	31.4	31.5	31.1
30-34	10.9	13.0	14.0	15.0	15.7	16.4	16.5	17.1	17.7	17.7	17.8
35-39	7.1	8.4	8.9	9.3	9.8	9.8	9.4	9.3	9.5	9.3	9.6
≥40**	2.9	3.3	3.6	3.7	3.9	3.6	3.4	3.5	3.4	3.3	3.1

Table 1. Number and percentage distribution of legal abortions, abortion rate per 1,000 women, and percentage of pregnancies terminated by abortion, by age, United States, 1973-1983. (Continued)

Measure	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Number of abortions											
Percentage of pregnancies terminated by abortion++											
Total	19.3	22.0	24.9	26.5	28.6	29.2	29.6	30.0	30.0	30.0	30.4
<15	25.6	29.0	33.4	35.8	41.1	40.9	43.0	42.7	43.7	42.9	46.0
15-19					38.3	39.5	40.6	41.1	41.2	41.2	42.2
15-17	n.a.	n.a.	n.a.	n.a.	(38.7)	(39.7)	(41.3)	(42.4)	(42.2)	(42.0)	(43.2)
18-19	n.a.	n.a.	n.a.	n.a.	(37.9)	(39.3)	(40.1)	(40.1)	(40.3)	(40.5)	(41.4)
20-24	17.6	20.0	22.8	25.0	27.6	28.7	29.4	30.1	30.4	30.6	31.4
25-29	13.2	15.4	17.2	18.6	20.2	20.8	21.1	21.8	22.0	22.3	22.5
30-34	18.7	21.7	23.5	23.1	23.7	23.5	23.0	23.3	23.9	23.2	23.0
35-39	28.3	32.8	35.4	36.6	38.5	38.6	37.3	37.2	35.7	34.2	34.2
≥40	39.7	44.4	48.6	50.2	52.5	51.6	50.4	51.7	51.3	51.4	51.4

* Denominator for total abortion rate is women aged 15-44.
\+ Numerator is abortions obtained by girls younger than 15; denominator is number of 14-year-old females.
** Numerator is abortions obtained by women 40 and over; denominator is women aged 40-44.
++ Denominator is live births six months later (to match time of conception with abortions) and abortions. Pregnancies exclude miscarriages and stillbirths. Births and abortions are adjusted to age of woman at time of conception.
Note: n.a.= unavailable.

Source: 1973-1981: S.K. Henshaw and E. Blaine, eds., Abortion Services in the United States, Each State and Metropolitan Area, 1981-1982, The Alan Guttmacher Institute, New York, 1985; 1982-1983: S.K. Henshaw, "Characteristics of U.S. Women Having Abortions, 1982-1983," Family Planning Perspectives, 19:5, 1987.

Table 2. Number and percentage distribution of abortions, abortion rate per 1,000 women aged 15-44, and percentage of pregnancies terminated by abortion, by race, 1973-1983.

Measure	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Number of abortions											
Total	744,610	898,570	1,034,170	1,179,300	1,316,700	1,409,600	1,497,670	1,553,890	1,577,340	1,573,920	1,575,000
White	548,790	629,320	701,170	784,890	888,780	969,410	1,062,400	1,093,630	1,107,770	1,095,260	1,084,360
Nonwhite	195,820	269,250	333,000	394,410	427,920	440,190	435,270	460,260	469,570	478,660	490,640
Percentage distribution of abortions											
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
White	73.7	70.0	67.8	66.6	67.5	68.8	70.9	70.4	70.2	69.6	68.8
Nonwhite	26.3	30.0	32.2	33.4	32.5	31.2	29.1	29.6	29.8	30.4	31.2
Abortion rate											
Total	16.3	19.3	21.7	24.2	26.4	27.7	28.8	29.3	29.3	28.8	28.5
White	14.0	15.7	17.2	18.8	20.9	22.3	24.0	24.3	24.3	23.8	23.3
Nonwhite	31.2	41.4	49.3	56.3	59.0	58.7	56.2	56.8	55.9	55.5	55.8
Percentage of pregnancies terminated by abortion											
Total	19.3	22.0	24.9	26.5	28.6	29.2	29.6	30.0	30.0	29.9	29.5
White	17.4	19.6	21.5	23.0	25.0	26.1	27.1	27.4	27.4	27.1	27.4
Nonwhite	25.9	31.6	35.9	38.9	40.4	39.6	38.2	39.2	39.2	39.2	40.1

Source: See source in Table 1.

Table 3. Number and percentage distribution of abortions, abortion rate per 1,000 women aged 15–44, and percentage of pregnancies terminated by abortion, by marital status, 1973–1983.

Measure	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Number of abortions											
Total	744,610	898,570	1,034,170	1,179,300	1,316,700	1,409,600	1,497,670	1,553,890	1,577,340	1,573,920	1,575,000
Married	216,210	248,150	271,870	290,030	299,710	330,630	322,210	319,880	298,510	300,260	294,670
Unmarried*	528,400	650,420	762,300	889,270	1,016,990	1,078,970	1,175,460	1,234,010	1,278,830	1,273,660	1,280,330
Percentage distribution of abortions											
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Married	29.0	27.6	26.3	24.6	22.8	23.5	21.5	20.6	18.9	19.1	18.7
Unmarried	71.0	72.4	73.7	75.4	77.2	76.5	78.5	79.4	81.1	80.9	81.3
Abortion rate											
Total	16.3	19.3	21.7	24.2	26.4	27.7	28.8	29.3	29.3	28.8	28.5
Married	8.0	9.2	10.0	10.6	10.9	12.0	11.6	11.3	10.5	10.5	10.3
Unmarried	28.4	33.4	37.5	41.7	45.8	46.1	48.7	49.7	50.1	48.6	48.1
Percentage of pregnancies terminated by abortion											
Total	19.3	22.0	24.9	26.5	28.6	29.2	29.6	30.0	30.0	29.9	29.5
Married	7.0	8.3	9.6	9.5	9.8	10.4	9.9	9.8	9.2	9.5	9.3
Unmarried	57.0	59.9	62.3	64.2	66.0	65.4	66.0	64.9	64.5	63.4	63.2

* Includes separated, divorced, widowed and never-married women.

Source: See source in Table 1.

Table 4. Number and percentage distribution of legal abortions, by selected characteristics, 1973-1983.

Characteristics	Number of Abortions										
	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Total	744,610	898,570	1,034,170	1,179,300	1,316,700	1,409,600	1,497,670	1,553,890	1,577,340	1,573,920	1,575,000
Number of live births											
0	410,850	482,530	542,470	629,300	742,450	798,070	868,240	900,030	911,880	902,780	890,000
1	114,860	155,490	194,130	228,710	249,430	271,270	287,050	304,760	312,200	321,000	329,460
2	103,580	130,130	156,010	176,350	186,470	198,050	206,990	215,620	219,880	222,760	227,600
3	60,520	70,260	77,530	81,390	79,980	83,290	82,070	82,870	84,480	81,720	82,890
≥4	54,800	60,160	64,030	63,550	58,370	58,920	53,320	50,610	48,900	45,660	45,050
Prior induced abortions											
0	u	762,060	822,080	911,320	972,530	996,460	1,025,340	1,042,960	1,022,890	994,470	964,170
1	u	112,550	170,440	213,240	271,530	316,880	351,830	372,480	389,780	397,890	406,030
2	u	17,110	30,400	40,400	54,040	70,270	86,340	97,290	112,670	122,480	138,350
≥3	u	6,850	11,250	14,340	18,600	25,990	34,160	41,160	52,000	59,080	66,450
Weeks of gestation*											
≤8	284,280	399,380	480,600	559,900	657,850	707,750	748,510	799,950	810,300	805,590	792,050
9-10	221,550	256,500	290,370	333,770	361,170	388,370	412,940	416,500	423,910	419,520	424,240
11-12	130,630	134,930	151,120	171,270	179,500	187,730	203,590	201,750	203,970	205,390	210,100
13-15	44,360	43,930	45,910	49,010	52,110	63,130	70,390	73,210	75,770	75,500	83,080
16-20	53,340	53,680	56,240	55,120	54,110	50,720	49,480	49,620	49,600	53,800	53,260
≥21	10,450	10,150	9,930	10,230	11,960	11,900	12,760	12,860	13,790	14,120	12,270
Method											
Instrumental evacuation+	667,720	813,170	948,560	1,101,420	1,236,220	1,334,030	1,421,710	1,486,510	1,518,050	1,518,950	1,524,720
Medical induction**	72,770	80,440	82,050	75,200	78,210	73,990	74,830	66,170	58,150	53,900	49,370
Hysterotomy/ hysterectomy	4,120	4,960	3,560	2,680	2,270	1,580	1,130	1,210	1,140	1,070	910

Table 4. Number and percentage distribution of legal abortions, by selected characteristics, 1973-1983. (Continued)

Characteristics	Percent of Abortions										
	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of live births											
0	55.2	53.7	52.4	53.4	56.4	56.6	58.0	57.9	57.8	57.3	56.5
1	15.4	17.3	18.8	19.4	18.9	19.2	19.2	19.6	19.8	20.4	20.9
2	13.9	14.5	15.1	14.9	14.2	14.1	13.8	13.9	13.9	14.1	14.4
3	8.1	7.8	7.5	6.9	6.1	5.9	5.5	5.3	5.4	5.2	5.3
≥4	7.4	6.7	6.2	5.4	4.4	4.2	3.5	3.3	3.1	3.0	2.9
Prior induced abortions											
0	u	84.8	79.5	77.3	73.9	70.7	68.4	67.1	64.9	63.2	61.2
1	u	12.5	16.5	18.1	20.6	22.5	23.5	24.0	24.7	25.3	25.8
2	u	1.9	2.9	3.4	4.1	5.0	5.8	6.3	7.1	7.8	8.8
≥3	u	0.8	1.1	1.2	1.4	1.8	2.3	2.6	3.3	3.7	4.2
Weeks of gestation*											
≤8	38.2	44.5	46.5	47.4	50.0	50.2	50.0	51.5	51.4	51.2	50.3
9-10	29.7	28.5	28.1	28.3	27.4	27.6	27.6	26.8	26.9	26.7	26.9
11-12	17.5	15.0	14.6	14.5	13.6	13.3	13.6	13.0	12.9	13.0	13.3
13-15	6.0	4.9	4.4	4.2	4.0	4.5	4.7	4.7	4.8	4.8	5.3
16-20	7.2	6.0	5.4	4.7	4.1	3.6	3.3	3.2	3.1	3.4	3.4
≥21	1.4	1.1	1.0	0.9	0.9	0.8	0.8	0.8	0.9	0.9	0.8
Method											
Instrumental evacuation+	89.7	90.5	91.7	93.4	93.9	94.6	94.9	95.6	96.2	96.5	96.8
Medical induction**	9.7	8.9	8.0	6.4	5.9	5.3	5.0	4.3	3.7	3.4	3.1
Hysterotomy/ hysterectomy	0.6	0.6	0.3	0.2	0.2	0.1	0.1	0.1	0.1	0.07	0.06

* Weeks since onset of last menstrual period.
\+ Suction and sharp curettage; includes dilation and evacuation at 13 weeks' gestation and later.
** Includes intrauterine instillation of saline, prostaglandin, urea, and in some cases combination procedures.
Note: u = unavailable

Source: See source in Table 1.

Table 5. Reported number of abortions (by occurrence), number of abortion providers, percent of abortions in nonhospital facilities with 400+ abortions, and percent of abortions in hospitals, by SMSA, 1984 and 1985.

SMSA	Number of Abortions		Number of Providers		Percent of Abortions in Nonhospitals (400+ Abortions)	Percent of Abortions in Hospitals
	1984	1985	1984	1985	1985	1985
Abilene, TX	0	0	0	0		
Akron, OH	7,600	7,170	6	6	99	1
Albany, GA	90	**	2	1	**	**
Albany, NY	4,060	4,270	21	21	**	**
Albuquerque, NM	3,400	3,930	13	15	67	13
Alexandria, LA	0	0	0	0		
Allentown, PA	4,320	4,430	9	9	**	**
Altoona, PA	0	0	0	0		
Amarillo, TX	**	**	1	1	**	**
Anaheim, CA	29,360	31,210	36	35	92	7
Anchorage, AK	2,390	2,660	6	6	79	9
Anderson, IN	0	0	0	0		
Anderson, SC	0	0	0	0		
Ann Arbor, MI	3,050	2,680	4	3	96	4
Anniston, AL	0	0	0	0		
Appleton, WI	**	**	1	1	**	**
Asheville, NC	2,060	2,100	4	4	93	1
Athens, GA	**	**	1	1	**	**
Atlanta, GA	31,810	31,620	30	29	76	23
Atlantic City, NJ	**	**	2	2	100	0
Augusta, GA	2,130	2,010	5	5	96	4
Austin, TX	7,930	7,850	12	12	81	14
Bakersfield, CA	5,660	6,020	8	8	**	8
Baltimore, MD	19,860	20,430	28	29	67	27
Bangor, ME	470	460	3	3	0	11
Baton Rouge, LA	4,720	3,840	6	6	93	0
Battle Creek, MI	**	**	1	1	**	**
Bay City, MI	0	0	0	0		
Beaumont, TX	**	**	1	1	**	**
Bellingham, WA	790	870	4		**	**
Benton Harbor, MI	**	**	2		99	**
Billings, MT	**	**	2		99	**
Biloxi, MS	**	**	2		100	0
Binghamton, NY	2,200	2,210	7		**	**
Birmingham, AL	7,450	7,310	11	11	93	6
Bismarck, ND	0	0	0	0		
Bloomington, IN	450	410	2	2	0	**
Bloomington, IL	0	0	0	0		
Boise City, ID	1,410	1,400	4	4	75	0
Boston, MA	29,060	32,410	60	58	82	14
Bradenton, FL	0	0	0	0		
Bremerton, WA	0	0	0	0		
Bridgeport, CT	7,590	7,890	14	14	86	5
Bristol, CT	8,630	8,830	13	13	54	44
Brownsville, TX	**	**	2	2	90	**
Bryan, TX	0	0	0	0		
Buffalo, NY	11,200	11,270	14	14	85	15
Burlington, NC	50	40	2	2	0	100
Burlington, VT	1,810	1,830	4	4	**	1
Canton, OH	**	**	1	1	**	**
Casper, WY	350	350	3	3	0	0
Cedar Rapids, IA	**	**	1	1	**	**
Champaign, IL	**	**	2	2	96	**
Charleston, SC	3,340	3,170	3	3	99	1
Charleston, WV	3,740	3,620	5	5	98	1

Table 5. Reported number of abortions (by occurrence), number of abortion providers, percent of abortions in nonhospital facilities with 400+ abortions, and percent of abortions in hospitals, by SMSA, 1984 and 1985. (Continued)

SMSA	Number of Abortions		Number of Providers		Percent of Abortions in Nonhospitals (400+ Abortions)	Percent of Abortions in Hospitals
	1984	1985	1984	1985	1985	1985
Charlotte, NC	6,690	6,970	7	8	92	8
Charlottesville, VA	**	**	3	3	75	**
Chattanooga, TN	2,110	1,930	6	6	**	**
Chicago, IL	52,800	52,410	41	40	95	5
Chico, CA	2,120	2,310	6	6	97	3
Cincinnati, OH	13,650	12,940	9	9	98	1
Clarksville, TN	0	0	0	0		
Cleveland, OH	14,960	15,110	14	14	91	9
Colorado Springs, CO	3,190	3,220	12	12	82	4
Columbia, MO	630	560	4	4	**	**
Columbia, SC	4,410	4,360	5	5	98	2
Columbus, GA	**	**	2	2	95	**
Columbus, OH	9,950	9,640	9	9	95	2
Corpus Christi, TX	2,850	2,800	4	4	94	0
Cumberland, MD	**	**	1	1	**	**
Dallas, TX	31,870	32,300	22	21	97	2
Danville, VA	0	0	0	0		
Davenport, IA	**	**	1	1	**	**
Dayton, OH	4,930	5,000	4	4	100	0
Daytona Beach, FL	2,090	2,330	5	5	97	1
Decatur, IL	0	0	0	0		
Denver, CO	18,780	18,590	40	41	81	8
Des Moines, IA	6,030	5,890	9	9	96	2
Detroit, MI	40,920	39,850	41	42	71	28
Dubuque, IA	0	0	0	0		
Duluth, MN	**	**	3	3	98	**
Eau Clair, WI	**	**	1	1	**	**
El Paso, TX	5,870	5,620	8	8	93	0
Elkhart, IN	0	0	0	0		
Elmira, NY	310	320	2	2	0	**
Enid, OK	0	0	0	0		
Erie, PA	0	0	0	0		
Eugene, OR	1,760	1,940	8	7	92	0
Evansville, IN	10	10	3	3	0	100
Fargo, ND	**	**	1	1	**	**
Fayetteville, NC	3,390	2,190	7	7	87	1
Fayetteville, AR	**	**	3	2	100	**
Flint, MI	4,820	4,650	5	5	73	27
Florence, AL	**	**	1	1	**	**
Florence, SC	0	0	0	0		
Fort Collins, CO	510	440	3	3	0	2
Fort Lauderdale, FL	14,060	13,970	18	18	98	2
Fort Myers, FL	**	**	3	3	79	0
Fort Smith, AR	**	**	1	1	**	**
Ft Walton Beach, FL	**	**	2	2	94	**
Fort Wayne, IN	**	**	2	2	100	0
Fresno, CA	7,350	7,770	4	4	**	**
Gadsden, AL	0	0	0	0		
Gainsville, FL	2,880	2,890	7	7	98	2
Galveston, TX	**	**	1	1	**	**
Gary, IN	3,170	2,720	6	5	**	5
Glens Falls, NY	160	150	3	3	0	20
Grand Forks, ND	**	**	1	1	**	**
Grand Rapids, MI	6,430	5,980	4	5	100	0
Great Falls, MT	870	790	4	4	0	**

Table 5. Reported number of abortions (by occurrence), number of abortion providers, percent of abortions in nonhospital facilities with 400+ abortions, and percent of abortions in hospitals, by SMSA, 1984 and 1985. (Continued)

SMSA	Number of Abortions		Number of Providers		Percent of Abortions in Nonhospitals (400+ Abortions)	Percent of Abortions in Hospitals
	1984	1985	1984	1985	1985	1985
Greeley, CO	**	**	3	3	72	4
Green Bay, WI	**	**	1	1	**	**
Greensboro, NC	8,100	7,730	19	20	93	5
Greenville, SC	**	**	2	2	100	0
Hagerstown, MD	**	**	2	2	99	**
Hamilton, OH	0	0	0	0		
Harrisburg, PA	6,470	5,400	7	6	95	5
Hickory, NC	**	**	3	3	91	**
Honolulu, HI	7,620	8,260	39	42	21	46
Houston, TX	29,320	30,530	20	20	99	0
Huntington, WV	0	0	0	0		
Huntsville, AL	**	**	3	3	96	**
Indianapolis, IN	9,850	10,290	13	12	82	18
Iowa City, IA	**	**	2	2	47	**
Jackson, MI	**	**	3	3	90	**
Jackson, MS	4,660	4,910	6	5	99	1
Jacksonville, FL	5,910	5,800	11	11	93	5
Jacksonville, NC	**	**	2	2	89	**
Janesville, WI	0	0	0	0		
Jersey City, NJ	3,100	3,670	3	3	97	0
Johnson City, TN	880	1,060	6	6	**	**
Johnstown, PA	10	0	2	2	0	0
Joplin, MO	0	0	0	0		
Kalamazoo, MI	**	**	3	3	97	**
Kankakee, IL	0	0	0	0		
Kansas City, MO	11,450	10,770	12	12	82	16
Kenosha, WI	320	320	3	3	0	0
Killeen, TX	**	**	1	1	**	**
Knoxville, TN	4,410	3,980	5	5	95	1
Kokomo, IN	0	0	0	0		
La Crosse, WI	**	0	1	0		
Lafayette, LA	0	0	0	0		
Lafayette, IN	**	**	1	1	**	**
Lake Charles, LA	0	0	0	0		
Lakeland, FL	**	**	3	3	95	**
Lancaster, PA	0	0	0	0		
Lansing, MI	3,510	3,310	4	4	92	8
Laredo, TX	**	**	1	1	**	**
Las Cruces, NM	**	**	1	1	**	**
Las Vegas, NV	5,950	6,760	19	19	81	1
Lawrence, KS	**	**	1	1	**	**
Lawton, OK	0	0	0	0		
Lewiston, ME	**	**	1	1	**	**
Lexington, KY	2,010	2,020	5	5	82	0
Lima, OH	0	0	0	0		
Lincoln, NE	710	680	4	4	**	**
Little Rock, AR	3,640	4,550	7	8	86	1
Long Branch, NJ	5,690	5,700	14	14	82	6
Longview, TX	0	0	0	0		
Lorain, OH	0	0	0	0		
Los Angeles, CA	102,190	100,360	146	145	72	25
Louisville, KY	7,980	7,820	6	6	97	3
Lubbock, TX	**	**	2	2	82	0
Lynchburg, VA	**	**	2	2	0	**
Macon, GA	220	220	4	4	0	14

Table 5. Reported number of abortions (by occurrence), number of abortion providers, percent of abortions in nonhospital facilities with 400+ abortions, and percent of abortions in hospitals, by SMSA, 1984 and 1985. (Continued)

SMSA	Number of Abortions		Number of Providers		Percent of Abortions in Nonhospitals (400+ Abortions)	Percent of Abortions in Hospitals
	1984	1985	1984	1985	1985	1985
Madison, WI	5,490	5,010	5	5	91	9
Manchester, NH	**	**	1	1	**	**
Mansfield, OH	0	0	0	0		
McAllen, TX	280	290	4	4	0	**
Medford, OR	1,010	1,070	11	11	**	4
Melbourne, FL	**	**	3	3	97	**
Memphis, TN	9,220	9,130	8	8	96	2
Miami, FL	13,660	14,150	22	22	86	12
Midland, TX	0	0	0	0		
Milwaukee, WI	10,420	9,990	11	11	96	2
Minneapolis, MN	15,990	15,490	13	13	89	10
Mobile, AL	3,630	3,740	5	5	99	0
Modesto, CA	5,240	5,540	6	5	**	**
Monroe, LA	0	0	0	0		
Montgomery, AL	5,290	5,380	3	3	100	0
Muncie, IN	0	0	0	0		
Muskegon, MI	**	**	2	2	80	**
Nashville, TN	5,710	6,000	13	13	87	6
Nassau, NY	17,380	17,270	30	30	71	23
New Bedford, MA	**	**	1	1	**	**
New Brunswick, NJ	10,360	10,550	9	9	89	7
New Haven, CT	3,830	3,710	12	12	57	29
New London, CT	**	**	2	2	92	**
New Orleans, LA	10,880	10,260	7	6	96	0
New York, NY	153,520	156,710	148	148	77	20
Newark, NJ	19,370	21,560	34	34	71	26
Newark, OH	0	0	0	0		
Newburgh, NY	190	240	5	5	0	79
Newport News, VA	2,500	2,380	7	7	**	**
Norfolk, VA	6,860	7,010	7	7	**	**
N.E. Penn, PA	350	410	2	2	0	0
Ocala, FL	**	**	1	1	**	**
Odessa, TX	2,740	2,490	3	3	100	0
Oklahoma City, OK	7,200	8,050	10	10	97	1
Olympia, WA	**	**	3	3	92	0
Omaha, NE	6,020	6,000	4	5	98	0
Orlando, FL	6,160	6,020	6	7	97	0
Owensboro, KY	0	0	0	0		
Oxnard, CA	8,820	9,000	20	20	94	2
Panama City, FL	20	20	2	2	0	**
Parkersburg, WV	0	0	0	0		
Pascagoula, MS	0	0	0	0		
Paterson, NJ	1,760	1,710	6	6	**	**
Pensacola, FL	**	**	3	3	85	**
Peoria, IL	**	**	2	1	**	**
Petersburg, VA	**	**	2	2	83	**
Philadelphia, PA	39,280	37,770	58	57	76	23
Phoenix, AZ	16,750	17,500	20	20	93	1
Pine Bluff, AR	0	0	0	0		
Pittsburgh, PA	16,690	14,980	25	24	86	7
Pittsfield, MA	500	500	4	4	0	**
Portland, ME	3,700	3,710	6	6	85	2
Portland, OR	12,640	12,070	22	23	42	55
Portsmouth, NH	2,450	2,920	10	8	91	3
Poughkeepsie, NY	1,230	1,280	7	6	**	**

Table 5. Reported number of abortions (by occurrence), number of abortion providers, percent of abortions in nonhospital facilities with 400+ abortions, and percent of abortions in hospitals, by SMSA, 1984 and 1985. (Continued)

SMSA	Number of Abortions		Number of Providers		Percent of Abortions in Nonhospitals (400+ Abortions)	Percent of Abortions in Hospitals
	1984	1985	1984	1985	1985	1985
Providence, RI	7,450	7,770	6	6	74	26
Provo, UT	0	0	0	0		
Pueblo, CO	0	0	0	0		
Racine, WI	0	0	0	0		
Raleigh, NC	9,740	9,620	12	12	88	9
Reading, PA	310	270	3	3	0	**
Redding, CA	**	**	3	3	74	**
Reno, NV	3,410	3,140	5	5	**	**
Richland, WA	0	0	0	0		
Richmond, VA	7,980	8,260	10	10	**	**
Riverside, CA	22,500	24,010	25	24	91	4
Roanoke, VA	3,130	3,260	6	6	89	3
Rochester, MN	**	**	1	1	**	**
Rochester, NY	7,490	7,400	35	35	39	22
Rockford, IL	**	**	1	1	**	**
Rock Hill, SC	**	**	1	1	**	**
Sacramento, CA	14,420	14,740	30	30	54	34
Saginaw, MI	2,180	2,870	4	4	86	14
St.Cloud, MN	0	0	0	0		
St.Joseph, MO	0	0	0	0		
St.Louis, MO	18,980	17,500	12	11	99	1
Salem, OR	**	**	2	2	0	**
Salinas, CA	1,880	1,810	8	8	**	**
Salisbury, NC	90	100	2	2	0	**
Salt Lake City, UT	4,210	4,440	6	7	**	2
San Angelo, TX	0	0	0	0		
San Antonio, TX	11,320	11,210	16	16	87	4
San Diego, CA	18,550	19,160	72	68	68	12
San Francisco, CA	46,420	48,270	114	116	58	30
San Jose, CA	17,320	17,660	36	34	65	22
Santa Barbara, CA	3,970	4,100	10	10	92	2
Santa Cruz, CA	2,120	1,830	3	3	99	1
Santa Rosa, CA	1,830	1,990	11	10	**	41
Sarasota, FL	3,130	3,150	4	4	69	24
Savannah, GA	2,270	2,310	4	4	**	**
Seattle, WA	20,060	20,490	47	47	73	12
Sharon, PA	0	0	0	0		
Sheboygan, WI	0	0	0	0		
Sherman, TX	0	0	0	0		
Shreveport, LA	**	**	2	2	100	0
Sioux City, IA	**	**	1	1	**	**
Sioux Falls, SD	**	**	1	1	**	**
South Bend, IN	**	**	1	1	**	**
Spokane, WA	**	**	2	2	79	**
Springfield, IL	0	0	0	0		
Springfield, MO	**	**	1	1	**	**
Springfield, OH	0	0	0	0		
Springfield, MA	4,830	5,170	6	6	85	15
State College, PA	0	0	0	0		
Steubenville, OH	0	0	0	0		
Stockton, CA	3,460	3,910	9	9	**	**
Syracuse, NY	3,980	3,980	8	8	87	9
Tacoma, WA	1,650	2,550	5	5	94	6
Tallahassee, FL	3,340	3,290	9	9	94	1
Tampa, FL	11,240	10,970	14	15	96	0

Table 5. Reported number of abortions (by occurrence), number of abortion providers, percent of abortions in nonhospital facilities with 400+ abortions, and percent of abortions in hospitals, by SMSA, 1984 and 1985. (Continued)

SMSA	Number of Abortions		Number of Providers		Percent of Abortions in Nonhospitals (400+ Abortions)	Percent of Abortions in Hospitals
	1984	1985	1984	1985	1985	1985
Terre Haute, IN	**	**	1	1	**	**
Texarkana, AR	0	0	0	0		
Toledo, OH	4,950	5,610	8	8	94	2
Topeka, KS	**	**	2	2	0	100
Trenton, NJ	610	640	4	4	0	95
Tucson, AZ	4,410	4,800	10	10	82	3
Tulsa, OK	5,310	4,910	4	4	99	0
Tuscaloosa, AL	**	**	2	2	76	**
Tyler, TX	**	**	1	1	**	**
Utica, NY	860	840	5	5	**	**
Vallejo, CA	1,310	1,250	4	4	**	**
Victoria, TX	0	0	0	0		
Vineland, NJ	0	0	0	0		
Visalia, CA	**	**	2	2	0	**
Waco, TX	0	0	0	0		
Washington, DC	40,260	42,210	41	41	85	13
Waterloo, IA	340	310	3	3	0	58
Wausau, WI	0	0	0	0		
W. Palm Beach, FL	5,170	5,740	8	8	95	1
Wheeling, WV	**	**	3	3	96	**
Wichita, KS	4,710	2,680	3	3	92	0
Wichita Falls, TX	**	**	1	2	100	**
Williamsport, PA	0	0	0	0		
Wilmington, DE	3,550	3,350	4	4	**	**
Wilmington, NC	560	410	3	3	0	**
Worcester, MA	1,600	1,950	6	5	**	**
Yakima, WA	2,350	2,550	6	7	79	0
York, PA	**	**	2	2	95	**
Youngstown, OH	**	**	2	2	97	**
Yuba City, CA	**	**	2	2	0	**

+ Providers of 1-4 abortions are rounded to zero.
** Suppressed to preserve confidentiality.

Table 6. SMSAs reporting fewer than 50 abortions, by state, 1985.

State and SMSA	State and SMSA	State and SMSA	State and SMSA
Alabama	Iowa	North Carolina	Texas
Anniston**	Davenport*	Burlington*	Abilene**
Florence*	Dubuque		Amarillo*
Gadsden		North Dakota	Bryan
	Kentucky		Galveston*
Arkansas		Bismarck	Longview
	Owensboro		Midland
Fort Smith*		Ohio	San Angelo**
Pine Bluff	Louisiana		Sherman
Texarkana		Canton*	Victoria
	Alexandria	Hamilton**	Waco
California	Lafayette	Lima	
	Lake Charles	Lorain	Utah
Visalia*	Monroe	Mansfield	
		Newark	Provo
Colorado	Maine	Springfield	
		Steubenville**	Virginia
Pueblo	Lewiston*		
		Oklahoma	Dansville
Florida	Maryland		
		Enid	Washington
Bradenton	Cumberland*	Lawton	
Panama City*			Bremerton
	Michigan	Pennsylvania	Richland
Georgia			
	Battle Creek*	Altoona*	West Virginia
Albany*	Bay City**	Erie	
Athens*		Johnstown*	Huntington
	Minnesota	Lancaster	Parkersburg
Illinois		Sharon**	
	St. Cloud	State College**	Wisconsin
Decatur		Williamsport	
Kankakee	Mississippi		Janesville
Springfield		South Carolina	Lacrosse
	Pascagoula		Racine
Indiana		Anderson	Sheboygan
	Missouri	Florence	Wausau
Anderson			
Bloomington	Joplin	Tennessee	
Elkhart	St. Joseph		
Evansville*		Clarksville	
Kokomo	New Jersey		
Muncie			
Terre Haute*	Vineland		

* SMSA reported between one and 50 abortions in 1985.
** SMSA may have small provider(s) who did not respond to survey in 1985.
SMSAs without asterisk did not report any abortions in 1985.

Table 7. Number and percentage distribution of reported abortions and providers by type of facility (hospitals, nonhospitals performing 400+ abortions and nonhospitals performing <400 abortions) and state, 1984 and 1985.

State and Type of Provider	Number of Abortions				Number of Providers			
	1984		1985		1984		1985	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Alabama	19,210	100	19,380	100	27	100	27	100
Hospital	470	2	490	3	11	41	11	41
Nonhospital 400+	18,470	96	18,620	96	12	44	12	44
Nonhospital <400	270	1	270	1	4	15	4	15
Alaska	3,170	100	3,450	100	15	100	13	100
Hospital	340	11	370	11	6	40	4	31
Nonhospital 400+	1,850	58	2,100	61	2	13	2	15
Nonhospital <400	980	31	980	28	7	47	7	54
Arizona	21,190	100	22,330	100	32	100	32	100
Hospital	360	2	320	1	3	9	3	9
Nonhospital 400+	19,020	90	20,210	91	11	34	11	34
Nonhospital <400	1,810	9	1,800	8	18	56	18	56
Arkansas	4,680	100	5,420	100	13	100	13	100
Hospital	70	1	80	1	6	46	6	46
Nonhospital 400+	3,900	83	4,510	83	4	31	4	31
Nonhospital <400	710	15	830	15	3	23	3	23
California	297,730	100	304,130	100	583	100	571	100
Hospital	60,030	20	57,200	19	300	51	292	51
Nonhospital 400+	218,580	73	226,020	74	113	19	108	19
Nonhospital <400	19,120	6	20,910	7	170	29	171	30
Colorado	24,600	100	24,350	100	70	100	71	100
Hospital	3,180	13	1,670	7	25	36	24	34
Nonhospital 400+	18,050	73	19,240	79	16	23	17	24
Nonhospital <400	3,370	14	3,440	14	29	41	30	42
Connecticut	21,490	100	21,850	100	47	100	47	100
Hospital	6,220	29	5,570	25	19	40	19	40
Nonhospital 400+	13,820	64	14,850	68	10	21	10	21
Nonhospital <400	1,450	7	1,430	7	18	38	18	38
Delaware	4,710	100	4,590	100	8	100	8	100
District of Columbia	23,690	100	23,910	100	15	100	16	100
Hospital	4,610	19	4,790	20	7	47	7	44
Nonhospital 400+	18,920	80	18,870	79	6	40	6	38
Nonhospital <400	160	1	250	1	2	13	3	19
Florida	75,800	100	76,650	100	125	100	127	100
Hospital	3,920	5	3,510	5	46	37	47	37
Nonhospital 400+	68,940	91	70,890	92	56	45	59	46
Nonhospital <400	2,940	4	2,250	3	23	18	21	17

Table 7. Number and percentage distribution of reported abortions and providers by type of facility (hospitals, nonhospitals performing 400+ abortions and nonhospitals performing <400 abortions) and state, 1984 and 1985. (Continued)

State and Type of Provider	Number of Abortions				Number of Providers			
	1984		1985		1984		1985	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Georgia	38,710	100	38,340	100	66	100	65	100
Hospital	7,570	20	7,700	20	43	65	41	63
Nonhospital 400+	29,650	77	29,630	77	11	17	13	20
Nonhospital <400	1,490	4	1,010	3	12	18	11	17
Hawaii	10,430	100	11,160	100	50	100	53	100
Hospital	4,550	44	4,480	40	13	26	13	25
Nonhospital 400+	3,260	31	3,490	31	4	8	4	8
Nonhospital <400	2,620	25	3,190	29	33	66	36	68
Idaho	2,740*	100	2,660*	100	11	100	11	100
Hospital	0	0	0	0	1	9	1	9
Nonhospital 400+	1,350	49	1,050	39	3	27	2	18
Nonhospital <400	1,390	51	1,610	61	7	64	8	73
Illinois	65,940	100	64,960	100	50	100	48	100
Hospital	3,450	5	2,820	4	27	54	26	54
Nonhospital 400+	62,170	94	62,110	96	20	40	20	42
Nonhospital <400	320	0	30	0	3	6	2	4
Indiana	16,070	100	16,090	100	30	100	28	100
Hospital	1,680	10	2,030	13	17	57	16	57
Nonhospital 400+	13,780	86	13,180	82	9	30	8	29
Nonhospital <400	610	4	880	5	4	13	4	14
Iowa	10,430	100	9,930	100	23	100	21	100
Hospital	2,230	21	1,910	19	10	43	8	38
Nonhospital 400+	7,170	69	7,110	72	6	26	6	29
Nonhospital <400	1,030	10	910	9	7	30	7	33
Kansas	12,420	100	10,150	100	18	100	18	100
Hospital	1,180	10	1,150	11	7	39	7	39
Nonhospital 400+	10,350	83	8,210	81	5	28	5	28
Nonhospital <400	890	7	790	8	6	33	6	33
Kentucky	10,090	100	9,820	100	12	100	12	100
Hospital	60	1	50	1	3	25	3	25
Nonhospital 400+	9,420	93	9,250	94	5	42	5	42
Nonhospital <400	610	6	520	5	4	33	4	33
Louisiana	20,730*	100	19,240*	100	16	100	15	100
Hospital	0	0	0	0	2	13	2	13
Nonhospital 400+	20,210	97	18,510	96	11	69	10	67
Nonhospital <400	520	3	730	4	3	19	3	20

Table 7. Number and percentage distribution of reported abortions and providers by type of facility (hospitals, nonhospitals performing 400+ abortions and nonhospitals performing <400 abortions) and state, 1984 and 1985. (Continued)

State and Type of Provider	Number of Abortions				Number of Providers			
	1984		1985		1984		1985	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Maine	5,180	100	4,960	100	25	100	24	100
Hospital	240	5	260	5	14	56	13	54
Nonhospital 400+	3,660	71	3,170	64	3	12	2	8
Nonhospital <400	1,280	25	1,530	31	8	32	9	38
Maryland	29,120	100	29,480	100	48	100	48	100
Hospital	5,530	19	5,930	20	28	58	27	56
Nonhospital 400+	22,460	77	22,320	76	11	23	12	25
Nonhospital <400	1,130	4	1,230	4	9	19	9	19
Massachusetts	36,340	100	40,310	100	80	100	77	100
Hospital	5,560	15	5,300	13	38	48	35	45
Nonhospital 400+	28,990	80	32,900	82	11	14	9	12
Nonhospital <400	1,790	5	2,110	5	31	39	33	43
Michigan	66,010	100	64,390	100	81	100	83	100
Hospital	14,970	23	13,360	21	32	40	35	42
Nonhospital 400+	50,230	76	50,170	78	39	48	38	46
Nonhospital <400	810	1	860	1	10	12	10	12
Minnesota	17,410	100	16,850	100	18	100	18	100
Hospital	2,090	12	1,710	10	10	56	10	56
Nonhospital 400+	15,220	87	15,010	89	6	33	6	33
Nonhospital <400	100	1	130	1	2	11	2	11
Mississippi	5,490	100	5,890	100	9	100	8	100
Hospital	50	1	30	1	3	33	3	38
Nonhospital 400+	5,220	95	5,860	99	4	44	5	63
Nonhospital <400	220	4	0	0	2	22	0	0
Missouri	22,140	100	20,100	100	26	100	25	100
Hospital	1,200	5	870	4	9	35	9	36
Nonhospital 400+	20,490	93	18,950	94	11	42	11	44
Nonhospital <400	450	2	280	1	6	23	5	20
Montana	3,880	100	3,710	100	15	100	14	100
Hospital	30	1	20	1	3	20	3	21
Nonhospital 400+	2,230	57	2,120	57	2	13	2	14
Nonhospital <400	1,620	42	1,570	42	10	67	9	64
Nebraska	6,730	100	6,680	100	8	100	9	100
Hospital	110	2	20	0	3	38	4	44
Nonhospital 400+	6,460	96	6,470	97	3	38	3	33
Nonhospital <400	160	2	190	3	2	25	2	22

Table 7. Number and percentage distribution of reported abortions and providers by type of facility (hospitals, nonhospitals performing 400+ abortions and nonhospitals performing <400 abortions) and state, 1984 and 1985. (Continued)

State and Type of Provider	Number of Abortions				Number of Providers			
	1984		1985		1984		1985	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Nevada	9,370	100	9,910	100	25	100	25	100
Hospital	80	1	90	1	4	16	4	16
Nonhospital 400+	7,700	82	8,200	83	3	12	3	12
Nonhospital <400	1,590	17	1,620	16	18	72	18	72
New Hampshire	6,740	100	7,030	100	20	100	20	100
Hospital	300	4	270	4	6	30	5	25
Nonhospital 400+	5,150	76	5,650	80	5	25	5	25
Nonhospital <400	1,290	19	1,110	16	9	45	10	50
New Jersey	65,860	100	69,190	100	101	100	102	100
Hospital	10,250	16	9,510	14	42	42	42	41
Nonhospital 400+	52,420	80	56,140	81	28	28	27	26
Nonhospital <400	3,190	5	3,540	5	31	31	33	32
New Mexico	5,380	100	6,110	100	25	100	28	100
Hospital	580	11	600	10	7	28	7	25
Nonhospital 400+	3,110	58	3,810	62	3	12	5	18
Nonhospital <400	1,690	31	1,700	28	15	60	16	57
New York	192,020	100	195,120	100	301	100	299	100
Hospital	41,530	22	40,680	21	153	51	148	49
Nonhospital 400+	140,150	73	143,560	74	59	20	58	19
Nonhospital <400	10,340	5	10,880	6	89	30	93	31
North Carolina	35,800	100	34,180	100	110	100	108	100
Hospital	3,830	11	3,020	9	71	65	67	62
Nonhospital 400+	29,700	83	29,130	85	18	16	19	18
Nonhospital <400	2,270	6	2,030	6	21	19	22	20
North Dakota	2,940	100	2,850	100	3	100	3	100
Hospital	0	0	0	0	0	0	0	0
Nonhospital	2,940	100	2,850	100	3	100	3	100
Ohio	58,040	100	57,360	100	54	100	54	100
Hospital	1,860	3	1,920	3	21	39	21	39
Nonhospital 400+	55,410	95	54,740	95	25	46	25	46
Nonhospital <400	770	1	700	1	8	15	8	15
Oklahoma	12,630	100	13,100	100	16	100	16	100
Hospital	120	1	120	1	4	25	4	25
Nonhospital 400+	12,220	97	12,680	97	6	38	6	38
Nonhospital <400	290	2	300	2	6	38	6	38

Table 7. Number and percentage distribution of reported abortions and providers by type of facility (hospitals, nonhospitals performing 400+ abortions and nonhospitals performing <400 abortions) and state, 1984 and 1985. (Continued)

State and Type of Provider	Number of Abortions				Number of Providers			
	1984		1985		1984		1985	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Oregon	15,310	100	15,230	100	52	100	50	100
Hospital	6,990	46	6,820	45	22	42	21	42
Nonhospital 400+	6,500	42	6,820	45	7	13	7	14
Nonhospital <400	1,820	12	1,590	10	23	44	22	44
Pennsylvania	60,680	100	57,370	100	105	100	101	100
Hospital	12,720	21	10,600	18	63	60	60	59
Nonhospital 400+	44,870	74	44,410	77	15	14	17	17
Nonhospital <400	3,090	5	2,360	4	27	26	24	24
Rhode Island	7,450	100	7,770	100	6	100	6	100
South Carolina	11,280	100	11,200	100	12	100	12	100
Hospital	100	1	120	1	3	25	3	25
Nonhospital	11,180	99	11,080	99	9	75	9	75
South Dakota	1,770	100	1,650	100	2	100	2	100
Tennessee	22,570	100	22,350	100	40	100	41	100
Hospital	1,230	5	730	3	20	50	21	51
Nonhospital 400+	20,240	90	20,550	92	12	30	11	27
Nonhospital <400	1,100	5	1,070	5	8	20	9	22
Texas	99,960	100	100,820	100	102	100	102	100
Hospital	1,170	1	1,150	1	19	19	19	19
Nonhospital 400+	94,730	95	95,600	95	50	49	51	50
Nonhospital <400	4,060	4	4,070	4	33	32	32	31
Utah	4,240	100	4,440	100	7	100	7	100
Hospital	70	2	70	2	2	29	2	29
Nonhospital	4,170	98	4,370	98	5	72	5	71
Vermont	3,450	100	3,430	100	16	100	16	100
Hospital	60	2	60	2	4	25	4	25
Nonhospital	3,390	99	3,370	98	12	75	12	76
Virginia	31,670	100	34,180	100	65	100	61	100
Hospital	3,150	10	3,100	9	45	69	41	67
Nonhospital 400+	27,640	87	30,190	88	11	17	11	18
Nonhospital <400	880	3	890	3	9	14	9	15

Table 7. Number and percentage distribution of reported abortions and providers by type of facility (hospitals, nonhospitals performing 400+ abortions and nonhospitals performing <400 abortions) and state, 1984 and 1985. (Continued)

State and Type of Provider	Number of Abortions				Number of Providers			
	1984		1985		1984		1985	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Washington	29,510	100	30,990	100	84	100	83	100
Hospital	3,500	12	3,370	11	32	38	33	40
Nonhospital 400+	21,500	73	23,480	76	17	20	18	22
Nonhospital <400	4,510	15	4,140	13	35	42	32	39
West Virginia	4,680	100	4,590	100	9	100	9	100
Hospital	180	4	120	3	3	33	3	33
Nonhospital 400+	4,460	95	4,430	97	4	44	4	44
Nonhospital <400	40	1	40	1	2	22	2	22
Wisconsin	18,640	100	17,830	100	26	100	25	100
Hospital	660	4	620	3	7	27	6	24
Nonhospital 400+	17,320	93	16,430	92	11	42	11	44
Nonhospital <400	660	4	780	4	8	31	8	32
Wyoming	1,060	100	1,070	100	8	100	8	100
Hospital	80	8	80	7	4	50	4	50
Nonhospital 400+	0	0	0	0	0	0	0	0
Nonhospital <400	980	92	990	93	4	50	4	50

* Providers of 1-4 abortions are rounded to zero.
Note: Percentages may not add to 100 due to rounding.
Some provider types are omitted to preserve confidentiality.

Table 8. Number of reported legal abortions by census division and state of occurrence, 1973-1982 and 1984-1985.

Census Division and State	Number of Abortions											
	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1984	1985
U.S. TOTAL	744,610	898,570	1,034,170	1,179,300	1,316,700	1,409,600	1,497,670	1,553,890	1,577,340	1,573,920	1,577,180	1,588,550
NEW ENGLAND	23,080	44,570	54,060	65,810	69,320	77,400	81,420	83,850	87,100	86,980	80,650	85,350
Connecticut	6,770	9,320	11,440	15,670	16,680	17,800	18,390	18,450	22,620	23,180	21,490	21,850
Maine	710	1,850	1,980	2,620	3,310	5,150	4,680	4,750	5,690	5,470	5,180	4,960
Massachusetts	12,400	27,800	33,260	38,340	39,310	42,610	45,110	45,590	41,660	41,250	36,340	40,310
New Hampshire	570	830	1,820	2,540	3,450	3,980	4,210	4,660	5,870	5,600	6,740	7,030
Rhode Island	1,140	2,910	3,310	3,890	4,200	4,570	5,650	6,640	7,500	7,770	7,450	7,770
Vermont	1,490	1,860	2,250	2,750	2,370	3,290	3,380	3,760	3,760	3,710	3,450	3,430
MIDDLE ATLANTIC	252,850	233,280	250,560	267,130	292,540	300,240	299,340	311,830	311,940	307,840	318,560	321,680
New Jersey	10,230	22,700	32,420	39,880	44,910	48,040	51,230	55,460	59,480	61,080	65,860	69,190
New York	212,700	168,960	170,690	170,900	185,580	187,050	183,190	187,460	187,610	182,700	192,020	195,120
Pennsylvania	29,920	41,620	47,450	56,350	62,050	65,150	64,920	68,910	64,850	64,060	60,680	57,370
EAST NORTH CENTRAL	97,430	131,530	166,630	199,740	211,880	216,820	237,470	242,900	230,160	227,550	224,700	220,630
Illinois	32,760	46,800	60,340	73,260	71,710	70,280	70,920	69,110	66,830	65,960	65,940	64,960
Indiana	1,760	5,990	7,680	8,720	10,370	15,340	18,910	19,630	16,040	15,680	16,070	16,090
Michigan	37,480	37,610	42,700	49,890	53,470	56,550	63,020	65,230	65,230	64,190	66,010	64,390
Ohio	17,270	30,400	44,600	53,420	60,190	57,140	64,380	67,140	60,700	61,440	58,040	57,360
Wisconsin	8,160	10,730	11,310	14,450	16,140	17,510	20,240	21,790	21,360	20,380	18,640	17,830
WEST NORTH CENTRAL	29,570	44,370	51,360	56,[illegible]0	62,410	63,820	69,730	75,240	74,070	73,170	73,840	68,210
Iowa	2,320	6,010	6,220	6,770	7,010	7,530	9,280	9,280	8,510	8,230	10,430	9,930
Kansas	12,560	13,420	14,320	12,990	14,700	12,870	13,720	13,570	14,530	14,440	12,420	10,150
Minnesota	7,340	11,610	12,790	15,680	17,150	17,580	19,080	19,920	19,900	19,020	17,410	16,850
Missouri	3,440	8,370	10,970	13,560	14,830	15,570	17,740	21,620	19,630	19,780	22,140	20,100
Nebraska	2,270	3,180	4,610	4,600	5,420	6,630	5,660	6,350	6,730	6,580	6,730	6,680
North Dakota	0	150	890	1,630	1,900	2,240	2,810	3,140	3,180	3,350	2,940	2,850
South Dakota	1,640	1,630	1,560	1,600	1,400	1,400	1,440	1,360	1,590	1,770	1,770	1,650
SOUTH ATLANTIC	114,370	142,970	172,410	190,820	212,200	236,030	247,310	254,530	270,580	270,370	255,460	257,120
Delaware	2,050	2,190	2,350	2,550	3,030	3,470	3,650	3,740	4,040	3,870	4,710	4,590
District of Columbia	44,550	33,010	31,440	32,150	31,640	30,850	28,670	28,520	30,310	28,630	23,690	23,910
Florida	22,850	30,390	46,500	51,110	57,340	63,470	70,190	73,580	77,040	76,910	75,800	76,650
Georgia	10,970	21,740	23,780	25,820	32,380	36,080	38,760	37,890	37,940	38,480	38,710	38,340
Maryland	11,070	17,140	21,820	23,580	23,710	25,780	28,020	30,490	33,970	34,810	29,120	29,480
North Carolina	12,260	16,850	19,960	23,710	24,960	30,120	30,370	31,890	33,220	33,230	35,800	34,180
South Carolina	2,180	5,120	6,170	5,750	8,870	13,050	13,170	13,660	15,200	16,140	11,280	11,200
Virginia	8,390	16,500	20,290	25,180	28,040	30,370	31,380	31,760	35,760	34,880	31,670	34,180
West Virginia	50	30	100	970	2,230	2,840	3,100	3,000	3,100	3,420	4,680	4,590

Table 8. Number of reported legal abortions by census division and state of occurrence, 1973-1982 and 1984-1985. (Continued)

Census Division and State	Number of Abortions											
	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1984	1985
EAST SOUTH CENTRAL	12,660	29,010	32,460	43,160	56,340	54,640	60,940	65,270	59,740	62,360	57,360	57,440
Alabama	4,630	5,080	6,020	8,350	11,680	15,120	17,590	20,780	19,840	19,930	19,210	19,380
Kentucky	2,600	7,750	8,540	10,200	11,440	12,470	12,860	12,820	10,230	10,830	10,090	9,820
Mississippi	110	380	310	1,670	2,780	4,010	5,060	6,080	5,430	5,500	5,490	5,890
Tennessee	5,320	15,800	17,590	22,940	30,440	23,040	25,430	25,590	24,240	26,100	22,570	22,350
WEST SOUTH CENTRAL	19,070	48,370	65,860	81,040	98,930	112,900	127,050	137,150	149,520	147,480	138,000	138,580
Arkansas	1,140	1,940	2,610	4,210	3,590	5,150	6,110	6,190	6,370	6,660	4,680	5,420
Louisiana	0	4,370	5,260	8,570	14,600	13,290	16,040	17,680	20,680	22,310	20,730	19,240
Oklahoma	590	4,350	6,780	7,550	10,000	11,180	10,820	11,280	12,360	12,690	12,630	13,100
Texas	17,340	37,710	51,210	60,710	70,740	83,280	94,080	102,000	110,110	105,820	99,960	100,820
MOUNTAIN	17,080	25,810	33,570	38,570	46,880	54,600	63,570	68,190	69,570	70,880	72,460	74,580
Arizona	2,770	5,610	6,730	7,930	9,600	13,370	14,500	15,790	16,500	15,830	21,190	22,330
Colorado	7,580	11,310	13,640	14,920	18,680	19,800	22,420	23,140	23,860	25,170	24,600	24,350
Idaho	380	780	1,080	1,330	1,740	1,800	2,050	2,740	3,010	3,020	2,740	2,660
Montana	450	1,240	1,490	1,670	2,280	3,100	3,550	3,670	4,190	4,230	3,880	3,710
Nevada	950	1,470	3,000	3,840	4,310	6,060	8,200	9,170	9,700	9,960	9,370	9,910
New Mexico	4,660	3,600	5,090	5,720	6,290	6,250	8,020	8,410	7,280	7,470	5,380	6,110
Utah	110	1,480	2,010	2,590	3,070	3,150	3,810	4,200	4,080	4,180	4,240	4,440
Wyoming	180	320	530	570	910	1,070	1,020	1,070	950	1,020	1,060	1,070
PACIFIC	178,500	198,660	207,260	236,200	266,200	293,150	310,840	314,930	324,660	327,290	356,150	364,960
Alaska	1,150	1,160	1,620	1,660	2,630	2,600	1,890	1,890	1,880	1,930	3,170	3,450
California	143,910	158,890	165,550	192,930	209,250	234,520	248,080	250,380	262,710	265,740	297,730	304,130
Hawaii	4,730	5,310	5,930	5,870	7,940	7,090	7,600	7,960	8,830	9,140	10,430	11,160
Oregon	11,440	13,390	13,270	12,820	15,070	14,450	17,690	17,670	15,990	16,350	15,310	15,230
Washington	17,270	19,910	20,890	22,920	31,310	34,490	35,580	37,030	35,250	34,130	29,510	30,990

Source: 1973-1982; S.K. Henshaw and E. Blaine, eds., Abortion Services in the United States, Each State and Metropolitan Area, 1981-1982, The Alan Guttmacher Institute, New York, 1983; 1984-1985: S.K. Henshaw, J.D. Forrest and J. Van Vort, "Abortion Services in the United States, 1984 and 1985," Family Planning Perspectives, 19:63, 1987.

Table 9. Reported legal abortions per 1,000 women aged 15-44, by census division and state of occurrence, 1973-1982 and 1984-1985.

Census Division and State	Abortion Occurrence Rate											
	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1984	1985
U.S. TOTAL	16.3	19.3	22.2	24.2	26.4	27.7	28.8	29.3	29.3	28.8	28.1	28.0
NEW ENGLAND	9.0	16.5	20.4	24.4	25.2	27.6	28.6	28.9	29.9	29.7	27.2	28.6
Connecticut	10.4	14.1	17.1	23.0	24.1	25.4	25.8	25.6	31.2	31.8	29.0	29.3
Maine	3.3	8.4	8.8	11.3	14.0	21.2	18.8	18.6	22.2	21.1	19.6	18.6
Massachusetts	10.1	22.4	26.4	29.9	30.2	32.2	33.6	33.5	30.6	30.2	26.4	29.3
New Hampshire	3.3	4.7	9.9	13.2	17.3	19.3	19.7	21.1	26.1	24.5	28.3	29.0
Rhode Island	5.8	14.7	16.5	19.1	20.3	21.7	26.5	30.7	34.7	35.8	34.1	35.5
Vermont	14.8	17.9	21.0	24.9	20.8	28.1	28.0	30.4	30.1	29.4	26.7	26.2
MIDDLE ATLANTIC	32.0	29.0	31.2	32.9	35.7	36.3	35.8	37.0	36.9	36.3	37.3	37.6
New Jersey	6.7	14.6	20.6	24.9	27.7	29.2	30.7	32.8	34.9	35.7	37.9	39.6
New York	54.5	43.1	43.3	43.0	46.3	46.4	45.1	45.8	45.8	44.5	46.6	47.4
Pennsylvania	12.2	16.8	18.9	22.2	24.2	25.1	24.8	26.1	24.4	24.1	22.6	21.3
EAST NORTH CENTRAL	11.1	14.8	18.4	21.7	22.7	22.9	24.7	24.9	23.5	23.1	22.6	22.1
Illinois	13.6	19.2	24.4	29.1	28.1	27.1	26.9	25.9	24.9	24.4	24.2	23.8
Indiana	1.5	5.1	6.5	7.2	8.5	12.3	15.0	15.3	12.4	12.1	12.2	12.2
Michigan	19.1	18.8	21.1	24.2	25.5	26.5	29.1	29.7	29.6	29.0	29.6	28.7
Ohio	7.4	13.0	18.8	22.3	24.8	23.3	25.9	26.8	24.1	24.3	22.7	22.4
Wisconsin	8.6	11.1	11.5	14.4	15.7	16.7	19.0	20.1	19.5	18.5	16.6	15.7
WEST NORTH CENTRAL	8.6	12.6	14.4	15.6	16.8	16.9	18.1	19.2	18.8	18.4	18.3	16.7
Iowa	4.0	10.2	10.4	11.1	11.3	11.9	14.5	14.3	13.0	12.6	15.8	15.0
Kansas	26.5	27.8	29.2	26.1	29.0	25.0	26.2	25.6	27.0	26.6	22.4	18.2
Minnesota	8.8	13.7	14.8	17.7	18.9	19.0	20.2	20.7	20.5	19.4	17.3	16.6
Missouri	3.5	8.3	10.7	13.0	13.9	14.4	16.1	19.4	17.4	17.4	19.2	17.3
Nebraska	7.2	10.0	14.2	13.9	16.1	19.3	16.2	17.9	18.8	18.3	18.4	18.2
North Dakota	0.0	1.2	6.7	12.1	13.8	15.9	19.6	21.5	21.5	22.4	19.3	18.5
South Dakota	12.2	11.9	11.2	11.3	9.7	9.6	9.7	9.0	10.5	11.6	11.4	10.6
SOUTH ATLANTIC	16.0	19.4	22.8	24.5	26.5	28.7	29.3	29.4	30.6	30.0	27.4	27.1
Delaware	16.3	17.0	17.9	19.1	22.2	24.9	25.7	25.9	27.8	26.5	31.8	30.9
District of Columbia	251.4	187.7	180.1	185.2	183.3	179.7	168.0	168.3	178.7	169.9	142.9	145.9
Florida	14.7	18.7	27.4	28.8	31.0	33.0	35.1	35.5	35.9	34.8	32.3	31.8
Georgia	10.0	19.2	20.4	21.5	26.3	28.5	29.8	28.4	27.8	27.7	26.8	26.1
Maryland	12.2	18.5	23.1	24.4	24.0	25.6	27.3	29.2	32.2	32.7	26.8	26.9
North Carolina	10.2	13.8	16.0	18.5	19.0	22.5	22.2	22.8	23.3	23.0	24.0	22.6
South Carolina	3.5	8.1	9.5	8.5	12.8	18.3	18.0	18.2	19.8	20.7	14.0	13.7
Virginia	7.6	14.6	17.5	21.1	22.9	24.2	24.4	24.2	26.8	25.7	22.6	24.0
West Virginia	0.1	0.1	0.3	2.4	5.5	6.8	7.3	6.9	7.1	7.7	10.4	10.1

Table 9. Reported legal abortions per 1,000 women aged 15-44, by census division and state of occurrence, 1973-1982 and 1984-1985. (Continued)

Census Division and State	Abortion Occurrence Rate											
	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1984	1985
EAST SOUTH CENTRAL	4.4	9.8	10.7	13.9	17.7	16.8	18.3	19.2	17.3	17.8	16.0	15.8
Alabama	6.0	6.4	7.4	10.1	13.8	17.5	19.9	23.1	21.7	21.6	20.3	20.2
Kentucky	3.6	10.6	11.4	13.2	14.5	15.4	15.5	15.1	11.9	12.5	11.4	11.0
Mississippi	0.2	0.8	0.6	3.2	5.2	7.3	9.0	10.6	9.3	9.3	9.1	9.7
Tennessee	5.8	16.9	18.3	23.3	30.2	22.3	24.0	23.6	22.0	23.3	19.5	19.1
WEST SOUTH CENTRAL	4.2	10.4	13.7	16.3	19.3	21.3	23.3	24.5	26.0	25.0	22.2	21.8
Arkansas	2.7	4.5	5.9	9.3	7.7	10.7	12.4	12.3	12.5	12.9	8.8	10.1
Louisiana	0.0	5.1	6.0	9.4	15.7	13.9	16.4	17.6	20.1	21.3	19.1	17.4
Oklahoma	1.0	7.4	11.2	12.2	15.7	17.1	16.1	16.4	17.6	17.6	16.8	17.1
Texas	6.4	13.5	17.7	20.3	22.8	26.0	28.5	30.0	31.3	29.2	26.0	25.5
MOUNTAIN	8.3	12.0	15.0	16.5	19.2	21.5	24.1	25.0	24.7	24.4	23.6	23.6
Arizona	6.1	11.8	13.4	15.0	17.3	23.1	23.9	25.0	25.2	23.4	29.2	29.9
Colorado	13.5	19.3	22.3	23.4	28.2	28.8	31.4	31.4	31.4	32.2	29.8	28.8
Idaho	2.3	4.5	6.0	7.1	9.0	8.9	9.8	12.7	13.6	13.4	11.6	11.1
Montana	3.0	7.9	9.3	10.1	13.5	17.8	19.9	20.1	22.6	22.5	20.1	19.0
Nevada	7.1	10.3	19.9	24.0	25.4	33.9	43.7	46.6	46.9	46.0	39.8	40.5
New Mexico	18.9	14.1	19.2	20.8	22.2	21.3	26.5	27.0	22.7	22.8	15.6	17.4
Utah	0.4	5.4	7.0	8.7	10.0	9.8	11.5	12.3	11.5	11.4	10.9	11.1
Wyoming	2.2	3.7	5.9	6.0	9.2	10.3	9.4	9.5	8.1	8.4	8.1	7.9
PACIFIC	28.5	30.8	31.2	34.4	37.7	40.3	41.6	41.0	41.4	40.8	42.6	42.8
Alaska	14.8	14.2	18.9	18.5	28.0	26.6	18.6	17.9	17.1	17.0	26.2	27.7
California	30.5	32.7	33.2	37.5	39.6	43.1	44.4	43.7	44.9	44.5	47.8	47.9
Hawaii	24.9	27.2	29.5	28.3	37.2	32.3	33.7	34.4	37.4	37.9	41.6	43.7
Oregon	23.3	26.3	25.1	23.4	26.6	24.6	29.2	28.3	25.1	25.2	22.8	22.3
Washington	21.8	24.3	24.7	26.2	34.6	37.0	37.0	37.5	34.8	32.9	27.2	28.0

Source: See source in Table 8.

Table 10. Number of abortions by state of residence, 1978-1982.

State of Residence	Number of Abortions				
	1978	1979	1980	1981	1982
U.S. TOTAL	1,409,600	1,489,460*	1,545,170*	1,566,230*	1,565,030*
Alabama	16,510	18,270	20,540	20,230	20,470
Alaska	3,110	2,400	2,340	2,300	2,350
Arizona	13,650	14,760	15,920	16,350	15,960
Arkansas	6,930	7,700	7,710	7,890	8,270
California	232,700	246,460	249,330	262,840	266,370
Colorado	18,480	20,930	21,670	21,980	23,620
Connecticut	20,040	20,380	19,860	24,370	24,610
Delaware	4,270	3,730	3,770	4,030	3,730
District of Columbia	14,680	14,210	15,100	15,720	15,390
Florida	56,460	67,550	70,760	74,270	74,070
Georgia	34,950	36,140	36,430	37,310	37,260
Hawaii	6,870	7,480	7,890	8,760	9,080
Idaho	2,650	2,890	3,370	3,490	3,460
Illinois	70,250	72,460	71,390	67,950	67,790
Indiana	24,650	24,710	25,230	21,290	20,490
Iowa	8,920	10,600	9,910	9,620	9,290
Kansas	8,630	8,940	9,030	9,530	9,670
Kentucky	12,910	11,770	11,710	9,300	9,710
Louisiana	12,970	17,460	19,360	20,940	23,730
Maine	5,420	4,530	4,750	5,800	5,410
Maryland	38,230	37,350	38,980	43,330	43,130
Massachusetts	40,760	43,350	44,240	42,730	42,670
Michigan	53,870	60,500	64,010	64,120	63,270
Minnesota	15,300	16,800	17,950	17,900	17,450
Mississippi	8,080	8,400	9,160	7,900	8,020
Missouri	20,180	22,330	25,180	23,460	22,730
Montana	3,720	3,720	3,710	3,610	3,440
Nebraska	5,000	4,340	5,140	5,630	5,650
Nevada	6,180	7,260	8,170	8,540	8,720
New Hampshire	4,520	4,810	5,280	4,990	4,780
New Jersey	57,640	58,720	62,110	64,290	65,630
New Mexico	6,590	7,900	8,370	9,390	8,960
New York	174,650	172,200	178,180	179,220	175,230
North Carolina	30,510	30,660	31,820	32,970	33,320
North Dakota	1,410	1,750	1,840	1,900	1,740
Ohio	56,170	64,330	65,880	59,710	60,310
Oklahoma	10,500	11,300	11,630	12,600	15,380
Oregon	15,950	19,170	18,100	15,930	16,240
Pennsylvania	62,650	63,600	67,810	64,860	64,010
Rhode Island	5,350	5,910	6,220	6,030	6,150
South Carolina	15,340	15,050	15,060	16,830	17,570
South Dakota	2,170	1,920	1,900	1,880	1,810
Tennessee	19,420	21,610	22,530	21,470	23,000
Texas	82,790	89,960	97,680	102,790	98,030
Utah	3,650	3,770	4,120	4,040	4,150
Vermont	3,260	3,330	3,650	3,170	3,060
Virginia	34,500	34,600	35,200	39,440	38,500
Washington	31,440	32,540	34,710	33,270	32,140
West Virginia	6,170	5,550	5,490	5,270	5,350
Wisconsin	16,510	21,280	22,720	22,570	21,510
Wyoming	2,040	2,080	2,260	2,420	2,350

* Excludes nonresidents of the United States who obtained abortions in the United States.

Note: The procedure for estimating state of residence changed somewhat after 1978.

Source: 1978-1981: S.K. Henshaw and E. Blaine, Abortion Services in the United States, Each State and Metropolitan Area, 1981-1982, The Alan Guttmacher Institute, New York, 1985; 1982: S.K. Henshaw, J.D. Forrest, and J. Van Vort, "Abortion Services in the United States, 1984 and 1985," Family Planning Perspectives, 19:66, 1987, Table 4.

Table 11. Reported legal abortions per 1,000 women aged 15-44, by state of residence, 1978-1982.

State of Residence	Abortions per 1,000 Women				
	1978	1979	1980	1981	1982
U.S. TOTAL	27.7*	28.6**	29.1**	29.1**	28.6**
Alabama	19.3	20.7	22.8	22.1	22.1
Alaska	27.5	23.6	22.1	20.9	20.7
Arizona	23.3	24.4	25.2	25.0	23.5
Arkansas	14.0	15.6	15.3	15.4	16.0
California	45.4	44.1	43.6	44.9	44.5
Colorado	26.6	29.3	29.4	28.9	30.2
Connecticut	28.6	28.6	27.5	33.6	33.7
Delaware	29.8	26.3	26.1	30.8	25.5
District of Columbia	82.5	83.3	89.1	92.7	91.1
Florida	28.6	33.8	34.1	34.7	33.5
Georgia	28.2	27.8	27.3	27.4	26.8
Hawaii	31.9	33.2	34.1	37.1	37.6
Idaho	13.2	13.8	15.6	15.8	15.3
Illinois	27.6	27.5	26.8	25.3	25.1
Indiana	20.5	19.5	19.7	16.5	15.8
Iowa	14.3	16.5	15.2	14.7	14.2
Kansas	17.0	17.1	17.0	17.7	17.8
Kentucky	16.1	14.2	13.8	10.9	11.2
Louisiana	14.3	17.8	19.3	20.4	22.6
Maine	22.0	18.2	18.6	22.6	20.9
Maryland	37.3	36.4	37.3	41.0	40.4
Massachusetts	30.4	32.3	32.5	31.4	31.2
Michigan	25.2	27.9	29.2	29.1	28.5
Minnesota	17.0	17.8	18.6	18.4	17.7
Mississippi	14.3	15.0	16.0	13.6	13.6
Missouri	18.8	20.3	22.6	20.8	20.0
Montana	20.6	20.8	20.3	19.5	18.3
Nebraska	14.1	12.4	14.5	15.8	15.7
Nevada	38.9	38.7	41.6	41.3	40.3
New Hampshire	23.8	22.5	24.0	22.2	20.9
New Jersey	35.0	35.2	36.7	37.8	38.3
New Mexico	22.0	26.1	26.8	29.3	27.3
New York	43.0	42.4	43.6	43.7	42.6
North Carolina	22.9	22.4	22.8	23.1	23.0
North Dakota	9.2	12.2	12.6	12.9	11.6
Ohio	23.1	25.9	26.3	23.7	23.8
Oklahoma	16.8	16.8	16.9	17.9	21.4
Oregon	29.5	31.6	28.9	25.0	25.0
Pennsylvania	24.3	24.3	25.7	24.4	24.0
Rhode Island	26.8	27.7	28.8	29.2	28.3
South Carolina	21.8	20.6	20.1	21.9	22.5
South Dakota	14.3	12.9	12.6	12.4	11.8
Tennessee	19.5	20.4	20.8	19.5	20.5
Texas	27.3	27.2	28.7	29.2	27.0
Utah	12.1	11.4	12.0	11.4	11.3
Vermont	29.9	27.6	29.5	25.4	24.2
Virginia	27.5	26.9	26.8	29.5	28.3
Washington	38.4	33.9	35.1	32.8	31.0
West Virginia	15.4	13.0	12.7	12.1	12.1
Wisconsin	15.9	19.9	20.9	20.6	19.5
Wyoming	20.6	19.2	20.0	20.7	19.3

* Population estimates used for 1978 were not corrected after the 1980 census.
** Excludes nonresidents of the United States who obtained abortions in the United States.

Source: See source in Table 10.

Table 12. Population aged 15-19; pregnancies, births, abortions, and miscarriages to females aged 15-19 at outcome; birth, abortion and pregnancy rates; by state, 1982.

State	Female Population	Births	Abortion by Residence	Estimated Miscarriages	Pregnancies (Births+ Abortions+ Miscarriages)	Rates per 1,000 females aged 15-19		
						Birth Rate	Abortion Rate	Pregnancy Rate
U.S. TOTAL**	9,767,000	513,760	418,740	144,630	1,077,130	53	43	110
Alabama*	175,180	11,100	5,900	2,820	19,820	63	34	113
Alaska*	16,770	1,210	660	310	2,180	72	39	130
Arizona	121,180	7,890	4,450	2,030	14,370	65	37	119
Arkansas	98,860	7,200	2,760	1,720	11,680	73	28	118
California	988,160	53,200	69,700	17,610	140,510	54	71	142
Colorado	126,110	6,500	6,290	1,930	14,720	52	50	117
Connecticut	131,030	4,260	7,120	1,570	12,950	33	54	99
Delaware*	28,010	1,440	1,110	400	2,950	51	40	105
District of Columbia	27,050	1,790	3,700	730	6,220	66	137	230
Florida*	388,220	23,120	22,050	6,830	52,000	60	57	134
Georgia	245,170	16,500	10,650	4,360	31,510	67	43	129
Hawaii	38,600	2,010	2,050	610	4,670	52	53	121
Idaho	41,970	2,340	980	570	3,890	56	23	93
Illinois	482,260	25,020	14,290	6,430	45,740	52	30	95
Indiana	243,240	12,580	5,970	3,110	21,660	52	25	89
Iowa*	126,400	4,730	2,770	1,220	8,720	37	22	69
Kansas	99,040	5,410	3,170	1,390	9,970	55	32	101
Kentucky*	159,200	10,850	2,850	2,460	16,160	68	18	102
Louisiana	202,690	15,470	5,780	3,680	24,930	76	29	123
Maine	48,830	2,190	1,520	590	4,300	45	31	88
Maryland	185,580	8,670	13,070	3,040	24,780	47	70	134
Massachusetts	251,170	7,280	9,900	2,450	19,630	29	39	78
Michigan	411,200	17,380	18,970	5,370	41,720	42	46	101
Minnesota	184,240	6,050	4,940	1,700	12,690	33	27	69
Mississippi	120,680	9,720	2,440	2,190	14,350	81	20	119
Missouri	210,200	11,280	6,620	2,910	20,810	54	31	99
Montana	33,730	1,650	920	430	3,000	49	27	89
Nebraska	67,460	2,790	1,760	730	5,280	41	26	78
Nevada	34,120	2,090	2,300	650	5,040	61	67	148
New Hampshire*	41,290	1,430	1,380	420	3,230	35	33	78
New Jersey	303,790	11,090	16,670	3,890	31,650	37	55	104
New Mexico	62,560	4,750	2,420	1,200	8,370	76	39	134
New York	727,280	27,530	41,150	9,620	78,300	38	57	108
North Carolina	259,760	14,890	10,070	3,990	28,950	57	39	111
North Dakota	29,020	1,250	590	310	2,150	43	20	74

Table 12. Population aged 15-19; pregnancies, births, abortions, and miscarriages to females aged 15-19 at outcome; birth, abortion and pregnancy rates; by state, 1982. (Continued)

State	Female Population	Births	Abortion by Residence	Estimated Miscarriages	Pregnancies (Births+ Abortions+ Miscarriages)	Rates per 1,000 females aged 15-19		
						Birth Rate	Abortion Rate	Pregnancy Rate
Ohio	460,050	23,050	14,360	6,040	43,450	50	31	94
Oklahoma	128,530	10,630	4,340	2,570	17,540	83	34	136
Oregon	104,890	4,790	4,790	1,440	11,020	46	46	105
Pennsylvania	492,550	20,290	17,670	5,820	43,780	41	36	89
Rhode Island	41,430	1,400	1,770	460	3,630	34	43	88
South Carolina	146,550	9,310	5,190	2,380	16,880	64	35	115
South Dakota	31,550	1,540	590	370	2,500	49	19	79
Tennessee	198,750	12,220	6,960	3,140	22,320	61	35	112
Texas*	641,780	49,540	25,840	12,500	87,880	77	40	137
Utah	68,320	4,220	1,000	940	6,160	62	15	90
Vermont	24,070	870	910	270	2,050	36	38	85
Virginia	232,280	11,000	11,120	3,310	25,430	47	48	109
Washington	171,220	7,650	8,630	2,400	18,680	45	50	109
West Virginia*	80,020	4,970	1,620	1,160	7,750	62	20	97
Wisconsin*	214,760	8,110	6,340	2,260	16,710	38	30	78
Wyoming	20,220	1,520	600	360	2,480	75	30	123

* Estimate based on proportion of abortions obtained by women of the same age in similar states.
** Columns may not sum to totals due to rounding.

Source: Numbers of women: estimated by interpolation between 1980 census data and unpublished population estimates for 1985 provided by Market Statistics, New York. Births: National Center for Health Statistics, unpublished tabulations. Abortions: the proportion of abortions obtained by women in the age group, from Centers for Disease Control, "Abortion Surveillance, 1982-1983," in CDC Surveillance Summaries, February 1987. MMWR, Vol. 36, No. 1SS, p.11SS-42SS (1987). This proportion was applied to the number of abortions to residents (Table 10). The figures were controlled to the U.S. totals in Table 1.

Table 13. Population aged 15-17; pregnancies, births, abortions, and miscarriages to females aged 15-17 at outcome; birth, abortion, and pregnancy rates, by state, 1982.

State	Female Population	Births	Abortion by Residence	Estimated Miscarriages	Pregnancies (Births+ Abortions+ Miscarriages)	Rates per 1,000 females aged 15-17		
						Birth Rate	Abortion Rate	Pregnancy Rate
U.S. TOTAL**	5,598,000	181,160	168,410	53,070	402,640	32	30	72
Alabama*	100,630	4,300	2,310	1,090	7,700	43	23	77
Alaska*	10,140	330	250	80	660	33	25	65
Arizona	69,210	2,740	1,430	700	4,870	40	21	70
Arkansas	58,290	2,660	1,070	640	4,370	46	18	75
California	562,170	17,750	27,960	6,350	52,060	32	50	93
Colorado	70,480	2,040	2,350	640	5,030	29	33	71
Connecticut	77,890	1,470	2,730	560	4,760	19	35	61
Delaware*	15,500	540	440	150	1,130	35	28	73
District of Columbia*	13,600	740	1,410	290	2,440	54	104	179
Florida*	224,870	8,650	8,580	2,590	19,820	38	38	88
Georgia	142,470	6,530	4,140	1,720	12,390	46	29	87
Hawaii	22,530	530	730	170	1,430	24	32	63
Idaho	23,400	730	320	170	1,220	31	14	52
Illinois	278,710	9,340	4,710	2,340	16,390	34	17	59
Indiana	138,350	4,410	2,100	1,090	7,600	32	15	55
Iowa*	70,880	1,390	1,020	380	2,790	20	14	39
Kansas	55,120	1,600	1,280	460	3,340	29	23	61
Kentucky*	91,830	4,070	1,080	920	6,070	44	12	66
Louisiana	115,980	5,840	1,570	1,320	8,730	50	14	75
Maine	28,540	660	510	180	1,350	23	18	47
Maryland	109,650	3,230	5,210	1,170	9,610	29	48	88
Massachusetts	139,470	2,380	2,530	730	5,640	17	18	40
Michigan*	237,540	5,990	6,320	1,830	14,140	25	27	60
Minnesota	104,380	1,710	1,550	500	3,760	16	15	36
Mississippi	69,530	3,970	1,000	900	5,870	57	14	84
Missouri	119,420	3,960	2,600	1,060	7,620	33	22	64
Montana	19,580	490	270	130	890	25	14	45
Nebraska	37,710	840	660	240	1,740	22	18	46
Nevada	20,070	670	910	230	1,810	33	45	90
New Hampshire*	23,080	400	460	130	990	17	20	43
New Jersey*	182,780	4,070	6,160	1,430	11,660	22	34	64
New Mexico*	36,650	1,690	850	420	2,960	46	23	81
New York	423,280	9,760	15,090	3,470	28,320	23	36	67
North Carolina	146,610	5,570	4,020	1,520	11,110	38	27	76
North Dakota	16,150	330	170	80	580	20	11	36

Table 13. Population aged 15-17; pregnancies, births, abortions, and miscarriages to females aged 15-17 at outcome; birth, abortion, and pregnancy rates, by state, 1982. (Continued)

State	Female Population	Births	Abortion by Residence	Estimated Miscarriages	Pregnancies (Births+ Abortions+ Miscarriages)	Rates per 1,000 females aged 15-17		
						Birth Rate	Abortion Rate	Pregnancy Rate
Ohio	263,860	7,890	4,670	2,050	14,610	30	18	55
Oklahoma	72,680	3,530	1,360	840	5,730	49	19	79
Oregon	59,800	1,470	1,900	480	3,850	25	32	64
Pennsylvania	280,590	7,220	6,630	2,110	15,960	26	24	57
Rhode Island	22,370	460	680	150	1,290	21	30	58
South Carolina	83,500	3,570	2,020	920	6,510	43	24	78
South Dakota	17,720	440	230	100	770	25	13	43
Tennessee	113,900	4,700	2,480	1,180	8,360	41	22	73
Texas*	366,080	18,150	23,640	5,990	47,780	50	65	131
Utah	36,690	1,240	340	280	1,860	34	9	51
Vermont	12,810	280	300	90	670	22	23	52
Virginia	133,550	3,880	4,210	1,210	9,300	29	32	70
Washington	97,910	2,390	3,250	800	6,440	24	33	66
West Virginia*	46,080	1,700	620	390	2,710	37	13	59
Wisconsin*	121,740	2,450	2,070	700	5,220	20	17	43
Wyoming	11,320	430	200	110	740	38	18	65

* Estimate based on proportion of abortions obtained by women of the same age in similar states.
** Columns may not sum to totals due to rounding.

Source: See source in Table 12.

Table 14. Population aged 18-19; pregnancies, births, abortions, and miscarriages to females aged 18-19 at outcome; birth, abortion, and pregnancy rates, by state, 1982.

State	Female Population	Births	Abortion by Residence	Estimated Miscarriages	Pregnancies (Births+ Abortions+ Miscarriages)	Rates per 1,000 females aged 18-19		
						Birth Rate	Abortion Rate	Pregnancy Rate
U.S. TOTAL**	4,169,000	332,600	250,330	91,550	674,480	80	60	162
Alabama*	74,550	6,800	3,600	1,730	12,130	91	48	163
Alaska*	6,630	890	410	220	1,520	134	62	229
Arizona	51,970	5,150	3,080	1,340	9,570	99	59	184
Arkansas	40,570	4,540	1,700	1,080	7,320	112	42	180
California	425,990	35,450	41,750	11,260	88,460	83	98	208
Colorado	60,550	4,470	3,960	1,290	9,720	74	65	161
Connecticut	53,140	2,800	4,410	1,000	8,210	53	83	154
Delaware*	12,510	900	680	240	1,820	72	54	145
District of Columbia*	13,450	1,050	2,300	440	3,790	78	171	282
Florida*	163,350	14,470	13,520	4,240	32,230	89	83	197
Georgia	102,700	9,970	6,530	2,650	19,150	97	64	186
Hawaii	16,070	1,490	1,330	430	3,250	93	83	202
Idaho	18,570	1,610	680	390	2,680	87	37	144
Illinois	203,550	15,670	9,750	4,120	29,540	77	48	145
Indiana	104,890	8,170	3,920	2,020	14,110	78	37	135
Iowa*	55,520	3,340	1,770	840	5,950	60	32	107
Kansas	43,920	3,800	1,880	950	6,630	87	43	151
Kentucky*	67,370	6,790	1,780	1,540	10,110	101	26	150
Louisiana	86,710	9,640	4,340	2,350	16,330	111	50	188
Maine	20,290	1,530	1,020	410	2,960	75	50	146
Maryland	75,930	5,440	7,870	1,870	15,180	72	104	200
Massachusetts	111,700	4,900	7,610	1,740	14,250	44	68	128
Michigan*	173,660	11,390	12,870	3,560	27,820	66	74	160
Minnesota	79,860	4,340	3,460	1,210	9,010	54	43	113
Mississippi	51,150	5,750	1,440	1,290	8,480	112	28	166
Missouri	90,780	7,320	4,020	1,860	13,200	81	44	145
Montana	14,150	1,160	670	300	2,130	82	47	151
Nebraska	29,750	1,940	1,110	500	3,550	65	37	119
Nevada	14,050	1,420	1,390	420	3,230	101	99	230
New Hampshire*	18,210	1,030	930	300	2,260	57	51	124
New Jersey*	121,010	7,020	10,610	2,460	20,090	58	88	166
New Mexico*	25,910	3,070	1,590	770	5,430	118	61	210
New York	304,000	17,760	26,300	6,190	50,250	58	87	165
North Carolina	113,150	9,320	6,060	2,470	17,850	82	54	158
North Dakota	12,870	920	420	240	1,580	71	33	123

Table 14. Population aged 18-19; pregnancies, births, abortions, and miscarriages to females aged 18-19 at outcome; birth, abortion, and pregnancy rates, by state, 1982. (Continued)

State	Female Population	Births	Abortion by Residence	Estimated Miscarriages	Pregnancies (Births+ Abortions+ Miscarriages)	Rates per 1,000 females aged 18-19		
						Birth Rate	Abortion Rate	Pregnancy Rate
Ohio	196,190	15,160	9,870	4,010	29,040	77	50	148
Oklahoma	55,850	7,100	3,050	1,730	11,880	127	55	213
Oregon	45,090	3,320	2,900	950	7,170	74	64	159
Pennsylvania	211,960	13,070	11,110	3,730	27,910	62	52	132
Rhode Island	19,060	940	1,100	300	2,340	49	58	123
South Carolina	63,050	5,740	3,170	1,470	10,380	91	50	165
South Dakota	13,830	1,100	370	260	1,730	80	27	125
Tennessee	84,850	7,530	4,530	1,960	14,020	89	53	165
Texas*	275,700	31,390	0	6,280	37,670	114	0	137
Utah	31,630	2,970	670	670	4,310	94	21	136
Vermont	11,260	590	620	180	1,390	52	55	123
Virginia	98,730	7,120	6,950	2,120	16,190	72	70	164
Washington	73,310	5,260	5,420	1,590	12,270	72	74	167
West Virginia*	33,940	3,270	1,010	760	5,040	96	30	148
Wisconsin*	93,020	5,660	4,360	1,570	11,590	61	47	125
Wyoming	8,900	1,090	400	260	1,750	122	45	197

* Estimate based on proportion of abortions obtained by women of the same age in similar states.
** Columns may not sum to totals due to rounding.

Source: See source in Table 12.

Table 15. Pregnancies, births, abortions, and miscarriages to females aged 14 or less at outcome, by state, 1982.

State	Births	Abortion by Residence	Estimated Miscarriages	Pregnancies (Births+ Abortions+ Miscarriages)
U.S. TOTAL**	9,770	14,590	3,410	27,770
Alabama*	270	280	90	640
Alaska*	10	20	0+	30
Arizona	130	140	40	310
Arkansas	160	110	40	310
California	840	2,260	410	3,510
Colorado	60	160	30	250
Connecticut	70	180	30	280
Delaware*	50	50	10	110
District of Columbia	60	180	30	270
Florida*	620	970	220	1,810
Georgia	480	500	140	1,120
Hawaii	20	50	20	90
Idaho	20	30	10	60
Illinois	550	340	150	1,040
Indiana	190	200	60	450
Iowa*	50	80	10	140
Kansas	50	100	30	180
Kentucky*	180	120	40	340
Louisiana	370	240	90	700
Maine	10	50	10	70
Maryland	210	600	100	910
Massachusetts	100	210	40	350
Michigan	320	850	150	1,320
Minnesota	60	90	20	170
Mississippi	350	120	80	550
Missouri	150	220	50	420
Montana	10	20	10	40
Nebraska	30	40	10	80
Nevada	30	70	20	120
New Hampshire*	10	40	10	60
New Jersey	250	750	120	1,120
New Mexico	60	60	30	150
New York	520	1,390	250	2,160
North Carolina	330	430	100	860
North Dakota	10	10	0+	20
Ohio	390	320	100	810
Oklahoma	130	150	40	320
Oregon	50	140	30	220
Pennsylvania	370	620	130	1,120
Rhode Island	10	30	0+	40
South Carolina	260	210	70	540
South Dakota	10	10	10	30
Tennessee	290	270	90	650
Texas*	1,090	860	290	2,240
Utah	30	20	10	60
Vermont	10	20	0+	30
Virginia	250	420	100	770
Washington	100	220	40	360
West Virginia*	60	70	10	140
Wisconsin*	90	240	40	370
Wyoming	20	30	0+	50

* Estimate based on proportion of abortions obtained by women of the same age in similar states.
\+ States with 1-4 miscarriages are rounded to zero.
** Columns may not sum to totals due to rounding.

Source: See source in Table 12.